TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
May 25, 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	Special Recognitions – Nurses & Support Staff of the Year for 2023 ➢ Nurse of the Year (Day Shift): Nick Bohanan, RN ➢ Nurse of the Year (Night Shift): Phuong Trieu, RN ➢ Patient Care Support Staff of the Year: Fe Schroeder – ACT	10 min.	Board Chair
6	April 2023 Financial Statement Results	10 min.	CFO
7	New Business - None	---	---
8	Chief of Staff - a) Consideration of May 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on May 22, 2023.	5 min.	COS

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

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

	Agenda Item	Time Allotted	Requestor
9	Consent Calendar – a) Approval of the renewal of the Emergency Department On-Call Coverage Panel for General Cardiology services to include Hanh Bui, M.D., Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, M.D. Anitha Rajamanickam, M.D., Pargol Samani, M.D., David Spiegel, M.D. and Aaron Yung, M.D. for a term of 12 months, beginning July 1, 2023 and ending, June 30, 2024, with an annual and total term cost of $109,000. b) Approval of the renewal of the Emergency Department On-Call Coverage Panel for Ophthalmology services to include Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garf, M.F., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D. Peter Krall, M.D., Vincent Q. Nguyen, M.D. Neta Vashney, M.D., Maulk Zaveri, M.D., and Charles Zenzen, M.D., for a term of 12 months, beginning July 1, 2023 and ending June 30, 2024, for an annual and total term cost of $128,100. c) Approval of the renewal of the Emergency Department Call Coverage Panel for Cardiology STEMI services to include Kenneth Carr, M.D., Karim El-Sherief, M.D., Anitha Rajamanickam, M.D., David Spiegel, M.D. and Aaron Yung, M.D. for a term of 12 months, beginning July 1, 2023 and ending June 30, 2024, with an annual and total term cost of $366,000. d) Approval of the renewal of the Emergency Department On-Call Coverage Panel for Urology services including Aaron Boonjindasup, M.D., Bradley Frasier, M.D., Michael Guerena, M.D., Jason Phillips, M.D. and Caroline Vilchis, M.D., for a term of 24 months, beginning July 1, 2023 and ending June 30, 2025, at a shared panal total term cost not to exceed $584,000. e) Approval of the renewal of the Emergency Department On-Call Coverage Panel for Otolaryngology services including Julie Berry, M.D., Robert Jacobs, M.D., Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Bruce Reisman, M.D., and Ashish Wadhwa, M.D., for a term of 24 months, beginning July 1, 2023 and ending June 30, 2025, for a total term cost of $475,150. f) Approval of the renewal of the comprehensive hospital based interventional radiology services agreement with San Diego Imaging Medical Group, for a term of 24 months, beginning July 1, 2023 and ending June 30, 2025, at an annual cost of $951,000 and a total term cost of $1,902,000. g) Approval of the renewal of the Medical Directorship for Physician Behavior Committee Chair with services provided by Victor Souza, M.D. for a term of 24 months, beginning June 1, 2023 and ending May 31, 2025, with a total term cost not to exceed $108,000. h) Approval of the agreement for the Medical Directorship for Clinical Data Integration & Information Technology with services provided by Scott Worman, M.D. for a term of 24 months, beginning June 1, 2023 and ending May 31, 2025, with a total term cost not to exceed $108,000. i) Approval of the renewal of a Professional Services Agreement for Aescalapius Medici, Inc. – Dr. Paul Lizotte for a renewal term of 12		

	Agenda Item	Time Allotted	Requestor
	months to provide Professional Services at Seaside Medical Group of Tri-City beginning May 1, 2023 and ending April 30, 2024, not to exceed a total expenditure of $300,000 over a 12-month term. j) Administrative Committees **1. Patient Care Services Policies & Procedures** a. Blanket Warmers Policy b. Cancer Education Procedure c. Neutropenic Precautions Policy d. Point of Use Pre-Cleaning of Reusable Instruments Policy e. PureWick Female Urinary Incontinence Management f. Visiting Guidelines **2. Administrative 200** a. Patients Injured by Deadly Weapon or Criminal Act 315 **3. Allied Health Professional** a. Certified Nurse Midwife Standardized Procedures b. Emergency Medicine NP Standardized Procedure c. Interventional Radiology Standardized Procedures d. Orthopedic and Spine Institute Standardized Procedures **4. Employee Health** a. Respiratory Protection Program **5. Infection Control** a. Bed Bugs, Identification and Control b. Construction c. Epidemiologic Investigation of a Suspected Outbreak d. Hand Hygiene e. Management of Patients with HIV-Infection/AIDS f. Meningococcal Exposure IC 6.2 g. Scabies and Lice h. Waterborne Illness i. Zika Virus **6. Medical Staff** a. Credentialing Standards Catheter-Based Peripheral Vascular Interventional Proc 8710-504 **7. Outpatient Behavioral Health Services** a. Physician Progress Note b. Psychiatric Emergencies c. Solicitation of Patients & Referral to Self **8. Outpatient Infusion Center** a. Ambulatory Infusion Pump (AIP) Policy b. Medical Record Review **9. Pulmonary** a. RCP Staffing Guidelines in the NIC **10. Security** a. BHU STAT Response #215 **11. Wound & Hyperbaric Oxygen** a. Hyperbaric Oxygen Therapy (HBOT) Consultation		

	Agenda Item	Time Allotted	Requestor
	k) Minutes 1) April 20, 2023 - Special Meeting 2) April 27, 2023 - Special Meeting 3) April 27, 2023 - Regular Meeting 4) May 10, 2023 - Special Meeting 5) May 11, 2023 - Special Meeting l) Meetings and Conferences – None m) Dues and Memberships – None n) Reports – (Discussion by exception only) 1) Lease Report – (April, 2023) 2) Reimbursement Disclosure Report – (April, 2023)		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1.5 hours	
16	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
May 10, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 5/26/2023 – 4/30/2025)

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 5/26/2023 through 4/30/2025:

- **AMMIRATI, Giuseppe MD/Radiology (California Center for Neurointerventional Surgery)**
- **CAVIN, Lillian MD/Teleradiology (SHPS)**
- **EDWARDS, Kenia MD/OB/GYN (TeamHealth)**
- **MYERS, Timothy MD/Teleradiology (SHPS)**
- **PIAMPIANO, Peter MD/Teleradiology (The Radiology Group)**
- **STUPIN, Jeremy MD/Teleradiology (Transparent Imaging)**
- **ZINN, William MD/Teleradiology (The Radiology Group)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
May 10, 2023

PROCTORING RECOMMENDATIONS

• BUONO, John , MD	Anesthesiology
• FAIQ, Nadia, MD	Emergency
• GHARIB, SayedMorteza , MD	Anesthesiology
• KUSHNIR, Matthew , MD	Anesthesiology
• MOON, Nah Yong , MD	OB/GYN
• PADILLA, Patrick , MD	Orthopedics
• PURCOTT, Kari , MD	OB/GYN
• SHAPIRO, Robert, MD	Urology
• RAJAMANICKAM, Anitha, MD	Interventional Cardiology
• VU, Quin , MD	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 1
May 10, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 06/01/2023 –05/31/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 06/01/2023 through 05/31/2025, 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:

- **AFRA, Robert, MD/Orthopedic Surgery/Active**
- **AJIR, Mahyar, DO/Family Medicine/Refer and Follow**
- **BIRHANIE, Melaku, MD/Internal Medicine/Active**
- **CARDOZA-FAVARATO, Gabriella, MD/Pathology/Provisional**
- **DEEMER, Andrew, MD/General and Vascular Surgery/Active**
- **ETEDALI, Elaheh, DO/Family Medicine/Refer and Follow**
- **FRAKES, Laurie, MD/Oncology/Active**
- **HWANG, Janice, MD/Teleradiology/Active Affiliate**
- **JAMSHIDI-NEZHAD, Mohammad,DO/General and Vascular Surgery/Active**
- **LINGENFELTER, David, MD/Obstetrics & Gynecology/Provisional**
- **MCGRAW, Jr., Charles, MD/Interventional Radiology/Active**
- **NOUD, Michael, MD/Interventional Radiology/Active**
- **PAL, Joshua, MD/Pain Medicine/Refer and Follow**
- **PATEL, Kiran, MD/Diagnostic Radiology/Active**
- **PATIL, Amol, MD/Diagnostic Radiology/Active**
- **SEIF, Joseph, MD/Anesthesiology/Active**
- **SILLDORFF, Morgan, MD/Orthopedic Surgery/Active**

Attachment B

- **STARK, Erik, MD/Orthopedic Surgery/Active**
- **TAO, Amy, MD/Obstetrics & Gynecology/Provisional**
- **TOMANENG, Neil, MD/Emergency Medicine/Active**
- **WONG, Richard, MD/Pathology/Active**
- **WORMAN, Scott, MD/Family Medicine/Active**
- **ZHAO, Zhong, MD/Internal Medicine/Active**

RESIGNATIONS: (Effective date 05/31/2023 unless otherwise noted)

Automatic:

- **HODSMAN, Hugh, MD/Family Medicine**

Voluntary:

- **DILLMAN, Ariana, MD/Emergency Medicine**
- **KOMMANA, Sandhya, MD/Telemedicine**
- **KUO, Frank, MD/Diagnostic Radiology**
- **KWON, Steven, MD/Telemedicine**
- **MCCUTCHEON, Claire, MD/Internal Medicine**
- **PAVEGLIO, Kathleen, MD/Cardiology**
- **SCHIM, Jack, MD/Neurology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
May 10, 2023

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of **May 26, 2023**

- **PADILLA, Patrick, MD** — **Orthopaedic Surgery**

ADDITIONAL PRIVILEGE REQUEST (Effective 5/26/2023)

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

- **VISEROI, Marius, MD** — **Pulmonary**

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, GENERAL

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

Vendor's Name: Hanh Bui, M.D., Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, M.D., Anitha Rajamanickam, M.D., Pargol Samani, M.D., David Spiegel, M.D., Aaron Yung, M.D.

Area of Service: Emergency Department On-Call: Cardiology, General

Term of Agreement: 12 months, Beginning, July 1, 2023 - Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal of current call panel; no increase in expense

Rate/Day	Term (Leap Year - 366 Days)	Annual Cost
$300	FY2024	$109,800
	Total Term Cost	**$109,800**

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Donald Dawkins, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for General Cardiology services to include Hanh Bui, M.D., Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, M.D., Anitha Rajamanickam, M.D., Pargol Samani, M.D., David Spiegel, M.D., and Aaron Yung, M.D., for a term of 12 months, beginning July 1, 2023 and ending, June 30, 2024, with an annual and total term cost of $109,800.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - OPHTHALMOLOGY

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

Physician's Names: Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D., Peter Krall, M.D., Vincent Q. Nguyen, M.D., Neeta Varshney, M.D., Maulik Zaveri, M.D., Charles Zenzen, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, July 1, 2023 – Ending, June 30, 2024

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

Rate/Day	Annual Cost (Leap Year - 366 days)	Total Term Cost
$350	$128,100	**$128,100**

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Donald Dawkins, Chief Nurse Executive

Motion:
I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for Ophthalmology Services to include Michael J. Ammar, M.D., Heather Chen, M.D., Jim Davies, M.D., Alexander S. Foster, M.D., Kevin Garff, M.D., Jessica Gomez, M.D., Logan Haak, M.D., Srinivas Iyengar, M.D., Atul Jain, M.D., Eric Johnston, M.D, Peter Krall, M.D., Vincent Q. Nguyen, M.D., Neeta Varshney, M.D., Maulik Zaveri, M.D., and Charles Zenzen, M.D., for a term of 12 months, beginning July 1, 2023 and ending June 30, 2024, for an annual and total term cost of $128,100.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, STEMI

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

Vendor's Name: Kenneth Carr, M.D., Karim El-Sherief, M.D., Anitha Rajamanickam, M.D, David Spiegel, M.D., Aaron Yung, M.D.

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

Term of Agreement: 12 months, Beginning, July 1, 2023 - Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal of current call panel; no increase in expense

Rate/Day	Term (Leap Year - 366 Days)	Annual Cost
$1,000	FY2024	$366,000
	Total Term Cost	**$366,000**

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Donald Dawkins, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for Cardiology STEMI services to include Kenneth Carr, M.D., Karim El-Sherief, M.D., Anitha Rajamanickam, M.D., David Spiegel, M.D., and Aaron Yung, M.D., for a term of 12 months, beginning July 1, 2023 and ending, June 30, 2024, with an annual and total term cost of $366,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
ED ON-CALL COVERAGE - UROLOGY

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

Physicians' Names: Aaron G. Boonjindasup, M.D., Bradley L. Frasier, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J. Vilchis, M.D.

Area of Service: Emergency Department On-Call: Urology

Term of Agreement: 24 months, Beginning July 1, 2023 – Ending June 30, 2025

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

Rate/Day	Term *(Leap Year – 366 Days)	Cost
$800	*FY2024	$292,800
	FY2025	$292,000
	Total Term Cost	**$584,800**

Description of Services:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Gene Ma, M.D., Chief Medical Officer

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call panel for Urology services to include Aaron G. Boonjindasup, M.D., Bradley L. Frasier, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., and Caroline J. Vilchis, M.D., for a term of 24 months, beginning July 1, 2023 and ending June 30, 2025, at a shared panel total term cost not to exceed $584,800.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ENT/Otolaryngology

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

Vendor's Name: Julie Berry, M.D., Robert Jacobs, M.D., Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Bruce Reisman, M.D., Ashish Wadhwa, M.D.

Area of Service: Emergency Department On-Call: ENT - Otolaryngology

Term of Agreement: 24 months, Beginning, July 1, 2023 - Ending, June 30, 2025

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

Rate/Day	Term	Annual Cost
$650	FY2024 (Leap Year – 366 Days)	$237,900
	FY2025	$237,250
	Total Term Cost	**$475,150**

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Donald Dawkins, Chief Nurse Executive

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call Coverage Panel for Otolaryngology services including Julie Berry, M.D., Robert Jacobs, M.D., Anton Kushnaryov, M.D., Jennifer MacEwan, M.D., Bruce Reisman, M.D., and Ashish Wadhwa, M.D., for a term of 24 months, beginning July 1, 2023 and ending, June 30, 2025, for a total term cost of $475,150.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
ED ON-CALL COVERAGE - UROLOGY

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

Physicians' Names: Aaron G. Boonjindasup, M.D., Bradley L. Frasier, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., Caroline J. Vilchis, M.D.

Area of Service: Emergency Department On-Call: Urology

Term of Agreement: 24 months, Beginning July 1, 2023 – Ending June 30, 2025

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

Rate/Day	Term *(Leap Year – 366 Days)	Cost
$800	*FY2024	$292,800
	FY2025	$292,000
	Total Term Cost	**$584,800**

Description of Services:

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

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

Person responsible for oversight of agreement: Bert Lawson, Director-Emergency Department / Gene Ma, M.D., Chief Medical Officer

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department On-Call panel for Urology services to include Aaron G. Boonjindasup, M.D., Bradley L. Frasier, M.D., Michael P. Guerena, M.D., Jason M. Phillips, M.D., and Caroline J. Vilchis, M.D., for a term of 24 months, beginning July 1, 2023 and ending June 30, 2025, at a shared panel total term cost not to exceed $584,800.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
Comprehensive Interventional Radiology Services

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

Physician Group Name: San Diego Imaging Medical Group (SDI)

Area of Service: Hospital Professional Services: Interventional Radiology

Term of Agreement: 24 months, Beginning July 1, 2023 – Ending June 30, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal, no change in rates, termination of separate ED call panel

Service	Annual Cost	Total Term Cost
Comprehensive Hospital Based Interventional Radiology Services including 24/7 Stroke Center Coverage	$876,000	$1,752,000
Specialty Advanced Nurse Practitioner	$75,000	$150,000
Totals	**$951,000**	**$1,902,000**

Description of Services/Supplies:

- Comprehensive coverage of all hospital-based services for interventional radiology to support all clinical service lines
- 24/7 coverage of ED call
- 24/7 Stroke center coverage with collaborative responsibility for achieving target metrics as a Joint Commission designated Thrombectomy Capable Stroke Center
- Backup coverage for diagnostic radiology services and procedures

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the comprehensive hospital based interventional radiology services agreement with San Diego Imaging Medical Group, for a term of 24 months, beginning July 1, 2023, and ending June 30, 2025, at an annual cost of $951,000 and a total term cost of $1,902,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
MEDICAL DIRECTOR - PHYSICIAN BEHAVIOR COMMITTEE CHAIR

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

Physician's Names: Victor Souza, M.D.

Area of Service: Medical Director- Physician Behavior Committee Chair

Term of Agreement: 24 months, Beginning June 1, 2023 – Ending May 31, 2025

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

Hourly Rate	Maximum Hrs. per Month	Maximum Cost per Month	Annual Cost	Total Term Cost
$150/hr.	30 hours	$4,500	$54,000 (NTE)	$108,000 (NTE)

Description of Services:

- Perform the duties of Chair of the Physician Behavior Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Be available as a resource to the Medical Staff and Hospital with respect to physician behavior issues
- Liaise with hospital Administration and Medical Staff on issues relating to physician behavior programs

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Medical Directorship for Physician Behavior Committee Chair with services provided by Victor Souza, M.D. for a term of 24 months, beginning June 1, 2023 and ending, May 31, 2025, with a total term cost not to exceed $108,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 25, 2023
PROFESSIONAL SERVICES AGREEMENT RENEWAL – DR. PAUL LIZOTTE

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

Physician's Name: Aescalapius Medici, Inc. - Dr. Paul Lizotte

Area of Service: Internal Medicine at Seaside Medical Group of Tri-City

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

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

Monthly Cost	**12 Month (Term) Cost**
$25,000	$300,000

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: Jeremy Raimo, Sr. Director Business Development / Dr. Gene Ma, Interim Chief Executive Officer

Motion:
I move that the TCHD Board of Directors authorize the renewal of a Professional Services Agreement for Aescalapius Medici, Inc. – Dr. Paul Lizotte for a term of 12 months to provide Professional Services at Seaside Medical Group of Tri-City, beginning May 1, 2023 and ending April 30, 2024, not to exceed a total expenditure of $300,000 over a 12-month period.

ADMINISTRATION CONSENT AGENDA
May 15th, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
1. Patient Care Services Policies & Procedures		
a. Blanket Warmers Policy	3 year review, practice change	Forward to BOD for Approval
b. Cancer Education Procedure	3 year review, practice change	Forward to BOD for Approval
c. Neutropenic Precautions Policy	3 year review	Forward to BOD for Approval
d. Point of Use Pre-Cleaning of Reusable Instruments Policy	NEW	Forward to BOD for Approval
e. PureWick Female Urinary Incontinence Management	RETIRE	Forward to BOD for Approval
f. Visiting Guidelines	3 year review	Forward to BOD for Approval
2. Administrative 200		
a. Patients Injured by Deadly Weapon or Criminal Act 315	3 year review	Forward to BOD for Approval
3. Allied Health Professional		
a. Certified Nurse Midwife Standardized Procedures	2 year review	Forward to BOD for Approval
b. Emergency Medicine NP Standardized Procedure	NEW	Forward to BOD for Approval
c. Interventional Radiology Standardized Procedures	2 year review	Forward to BOD for Approval
d. Orthopedic and Spine Institute Standardized Procedures	2 year review	Forward to BOD for Approval
4. Employee Health		
a. Respiratory Protection Program	3 year review, practice change	Forward to BOD for Approval
5. Infection Control		
a. Bed Bugs, Identification and Control	3 year review	Forward to BOD for Approval
b. Construction	3 year review	Forward to BOD for Approval
c. Epidemiologic Investigation of a Suspected Outbreak	3 year review	Forward to BOD for Approval
d. Hand Hygiene	3 year review	Forward to BOD for Approval
e. Management of Patients with HIV-Infection/AIDS	3 year review	Forward to BOD for Approval
f. Meningococcal Exposure IC 6.2	3 year review	Forward to BOD for Approval
g. Scabies and Lice	3 year review	Forward to BOD for Approval
h. Waterborne Illness	3 year review	Forward to BOD for Approval
i. Zika Virus	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
May 15th, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
6. Medical Staff		
a. Credentialing Standards Catheter-Based Peripheral Vascular Interventional Proc 8710-504	3 year review	Forward to BOD for Approval
7. Outpatient Behavioral Health Services		
a. Physician Progress Note	3 year review	Forward to BOD for Approval
b. Psychiatric Emergencies	3 year review	Forward to BOD for Approval
c. Solicitation of Patients & Referral to Self	3 year review	Forward to BOD for Approval
8. Outpatient Infusion Center		
a. Ambulatory Infusion Pump (AIP) Policy	3 year review	Forward to BOD for Approval
b. Medical Record Review	3 year review, practice change	Forward to BOD for Approval
9. Pulmonary		
a. RCP Staffing Guidelines in the NICU	3 year review	Forward to BOD for Approval
10. Security		
a. BHU STAT Response #215	RETIRE	Forward to BOD for Approval
11. Wound & Hyperbaric Oxygen		
a. Hyperbaric Oxygen Therapy (HBOT) Consultation	3 year review	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/09 **SUBJECT:** Blanket Warmers

REVISION DATE: 08/12, 04/17

Department Approval:	~~03/20~~03/23
Clinical Policies & Procedures Committee Approval:	~~03/20~~04/23
Nursing Leadership~~Executive Council~~ Approval:	~~04/20~~05/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
1. To ensure patient safety while using warmed blankets through proper use of blanket warmers.

B. **POLICY:**
1. Blanket warmers shall be maintained according to manufacturer's instructions for use (IFU).
2. Blankets are stored in the blanket storage compartment of the warmer unit.
3. The warmer is not to be overfilled. Leave approximately two inches between stack of blankets and the roof and walls of the blanket warmer.
4. Blanket warmer thermostats shall be set to a maximum temperature of 130°F.
   a. The temperature should be monitored any time a blanket is removed. Staff should assess the temperature gauge prior to removing blankets from the warmer.
   b. If blanket warmer temperature gauge is found to be above 130°F~~:~~:
      i. Enter a work order and call Building Engineering department.
      ii. Place blanket warmer out of service.
      iii. Do not use blankets ~~if the blankets are overheated~~ until the temperatures ~~is~~**are** within acceptable range.
5. Blanket warmers shall be used for clean blankets only.

C. **RELATED DOCUMENT(S):**
1. Blanket Warmer List

D. **REFERENCES:**
1. ECRI Institute Continues to Recommend Maximum Temperature Setting of 130 Degrees Fahrenheit for Blanket Warming Cabinets: https://www.ecri.org/components/PSOCore/Pages/PSMU040114_ecri.aspx; Published April 1, 2014. Retrieved March 5, 2020.
2. AORN, Inc. (202~~0~~**3**). *Guidelines for Perioperative Practice*. Denver.
3. The Joint Commission: Medical Equipment-Blanket Temperature Risk Assessment: https://www.jointcommission.org/en/standards/standard-faqs/hospital-and-hospital-clinics/environment-of-care-ec/000001220/; Updated February 21, 2018. Retrieved **October 21, 2021**~~March 5, 2020~~.

Blanket Warmer List

Tri City Mediacal Center & All Outpatient Clinics

Site Code: 17823

Asset ID #	Equipment Location	Manufacturer	Model #	Serial #
BW-01	ED	AMSCO	QDJ04	0406309035
BW-02	ED	AMSCO	QDJ01	0413593004
BW-03	1 North	PEDIGO	P-2010S	359983-000
BW-04	PolyStar/ MultiStar			
BW-05	2 Pavilion	PEDIGO	P-2010S	359982-000
BW-06	3 Pavilion	Enthermics	DC350	1325181-000
BW-07	4 Pavilion	PEDIGO	P-2010S	555897-000
BW-08	ICU	AMSCO	QDJO3	046897006
BW-09	2 East	Enthermics	DC350	1213722-000
~~BW-10~~	~~NICU~~	~~PEDIGO~~	~~P-2010S~~	
BW-11	3 East	FHC	SWC 24	0111807-703
BW-12	4 East	Enthermics	DC350	1196004-000
BW-13	Surgery /PACU	AMSCO	QDJ04	0401894024
BW-14	Pre-Op	AMSCO	QDJ04	0460793015
~~BW-15~~	~~OR1 &2 Sterile Storage~~			
BW-16	OR1	AMSCO	QDJ04	0403394101
BW-17	OR2	AMSCO	QDJ04	0401994050
BW-18	OR3	AMSCO	QDJ04	0401994049
BW-19	OR4	AMSCO	QDJ04	0403294012
BW-20	OR5	AMSCO	QDJ04	0403394105
BW-21	OR6	AMSCO	QDJ04	0401994048
BW-22	OR7	AMSCO	QDJ04	0401094006
BW-23	OR8	AMSCO	QDJ04	0403394106
BW-24	OR9	AMSCO	QDJ04	0403294014
BW-25	OR10	AMSCO	QDJ04	0403394103
BW-26	OR11	AMSCO	QDJ04	0403394104
BW-27	OR12	AMSCO	QDJ04	0403294015
BW-28	WCOR1	AMSCO	QDJ04	0401894027
BW-29	WCOR3	AMSCO	QDJ01	0401206080
BW-30	Post Partum	AMSCO	QDJ04	0401194033
BW-31	L&D Recovery	AMSCO	QDJ04	0401894021
BW-32	L&D	AMSCO	QDJ04	0401894023

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CANCER EDUCATION**
Purpose:	To outline the educational needs of cancer patients at Tri-City Healthcare District (TCHD).
Equipment:	American Cancer Referral Form and TCHD Intranet

A. **PROCEDURE:**

1. Patients admitted to TCHD with a diagnosis of cancer, and their families, will be offered the choice of a referral to the American Cancer Society for continuity of care, which offers patients/families support in areas including, but not limited to:
   a. Current Cancer Treatment and Research
   b. Financial Support (e.g., medications, transportation to treatments, child care)
   c. Support Groups (e.g., Look Good and Feel Good Program, Road to Recovery, Man to Man, Breast Cancer Support)
   d. Sponsor Program
   e. Clinical Trials
   f. Managing Your Cancer Experience
   g. Resources for a Healthy Life
2. Patients admitted to TCHD with a diagnosis of cancer, and their families, will be given information on how to participate in and access information on clinical trials. This educational information for patients/families is located on the Tri-City Intranet under Patient Information - Learn About and Find Clinical Trials. Patients/families can also access this information by calling ~~1-800-303-5691 from~~ the American Cancer Society.
3. If the patient/family would like to be referred to the American Cancer Society, social worker, case manager the Registered Nurse (RN) shall:
   a. Have patient/family complete the American Cancer Society Referral Form (Tri-City Intranet under Patient Information). The registered nurse, social worker or case manager may assist patient in completing the form if patient is unable to complete the form independently but verbally agrees to the referral.
   b. Fax the form to the American Cancer Society (fax number is on the form).

~~4. A representative from the American Cancer Society will contact patient/family.~~

~~5.~~**4.** The following are other educational resources for cancer patients and their family. (Handout for patients is available on the Tri-City intranet under Departments > Clinical > References > Patient Information > Cancer Resources.)

a.	National Comprehensive Cancer Network	www.nccn.com/
b.	Cancer Action Network	www.acscan.org
c.	Cancer Survivor's Network	csn.cancer.org/
d.	Cancer Research	www.cancer.org
e.	American Cancer Society	www.cancer.org~~/docroot/home/index.asp~~
f.	American Institute for Cancer Research	*www.aicr.org*
g.	American Society of Clinical Oncology	*www.asco.org*
h.	Cancer News on the Net	*www.cancernews.com*
i.	CancerNet (National Cancer Institute)	*cancernet.nci.nih.gov*
~~j.~~	~~Cansearch: A Guide to Cancer Resources on the Internet~~	~~*www.cansearch.org/canserch*~~
~~k.~~**j.**	National Cancer Institute's bibliographic database	*cnetdb.nci.nih.gov/cancerlit.shtml*
~~l.~~**k.**	National Cancer Institute's - clinical trials information	*cancertrials.nci.nih.gov*
~~m.~~**l.**	Department of Health and Human Services	*www.healthfinder.gov*

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration Approval	Professional Affairs Committee	Board of Directors
07/10, 07/13, 06/17, **02/23**	08/10, 07/13, 07/17, **02/23**	09/10, 07/13, 07/17, **03/23**	03/19, **03/23**	n/a	07/13, 05/19, **04/23**	06/19, **05/23**	09/10, 08/13, n/a	09/10, 08/13, 06/19

~~6.~~**5.** Additional educational materials are available for cancer patients and their families in the following areas:
   a. Tri-City Intranet:
      i. Clinical Key
      ii. Elsevier Online Patient Education (under Policies and Procedures link on Intranet)
   b. Cerner:
      i. Patient Education Handouts ~~(such as Krames)~~
   c. Education Pamphlets on 2 Pavilion

~~7.~~**6.** Document all referrals and cancer education in the **electronic health record** ~~Cerner AdHoc form under Education All Topics Form -- "Cancer/Chemo/Radiation."~~

B. **FORM(S):**
1. American Cancer Society Referral Form PPROA

C. **EXTERNAL LINK(S):**
1. American Cancer Society- Learn About and Find Clinical Trials: https://www.cancer.org/treatment/treatments-and-side-effects/clinical-trials/clinical-trials-matching-service-find-trial.html

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/13 **SUBJECT:** Neutropenic Precautions

REVISION DATE: 06/13, 01/17, 05/20

Patient Care Services Content Approval:	~~11/19~~10/22
Clinical Policies & Procedures Committee Approval:	~~12/19~~01/23
Nurse Executive Council Approval:	~~02/20~~02/23
Infection Control Committee Approval:	~~03/20~~04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~04/23
Administration Approval:	~~05/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **POLICY:**
1. To outline steps for preventing infections in patients with neutropenia.
2. Patients who are identified as neutropenic have the greatest risk for infection
3. Neutropenia is defined as an absolute neutrophil count [ANC] of <500 cells/mL
4. The primary nurse must educate the patient and family on neutropenic precautions.

B. **PROCEDURE:**
1. If patient has been identified as having an ANC of <500 cells/mL move patient to a private room.
2. Do not place patient in a negative pressure room unless patient requires respiratory isolation for Airborne Precautions per the Tri-~~c~~City Medical Center's infection control manual.
3. Place sign outside of the patient's room that states "please check in with the nurses' station before entering the room". Never place a sign that states "neutropenia". This is a Health Insurance Portability and Accountability Act (HIPAA) violation.
4. Do not allow staff or visitors who have symptoms of respiratory infection to visit or care for patient
5. All visitors:
   a. Must be screened for respiratory infections
   b. Must perform hand hygiene before entering the patient's room.
6. Children must be accompanied by a responsible adult (other than the patient) at all times when visiting.
   a. Only one child may visit at a time.
   b. All children must wear a mask if visiting patient.
7. Healthcare team, patient, family and visitors must adhere to neutropenic precautions.
8. Neutropenic Precautions:
   a. Hygiene
      i. All healthcare team members must use standard precautions and **perform**~~do~~ hand hygiene frequently when caring for neutropenic patients
      ii. Patient must wash hands frequently and ensure they are dried properly
      iii. Patient should keep their skin clean and dry at all times (bathe daily)
      iv. Patient must protect skin from cuts and burns
      v. Patient must perform daily oral care
      vi. Only use an electric shaver to remove hair (no razors).
      vii. Patient's perineal area should be cleansed after voiding and bowel movement
      viii. Menstruating women should avoid tampons

ix. Rectal thermometers, enemas, suppositories and rectal examinations are contraindicated

b. Visitors
   i. No visitors with respiratory infections
   ii. Patient should avoid people with colds or contagious illness such a chicken pox, herpes zoster or influenza

c. Environment
   i. No fresh or dried plants and flowers in patient room
   ii. Change the water of any water containers or pitchers and denture cups daily

d. Food/Food Preparation
   i. Patient should not eat any foods that have not either been cooked or washed properly.
   ii. Food items for the patient from the cafeteria must be covered when transported to the unit for the patient
   iii. Fruits and vegetables should be well washed before eating
   iv. Avoid uncooked meats, seafood, and eggs
   v. Patient should not share food utensils

e. Vaccinations
   i. Influenza and pneumonia vaccinations are recommended
   ii. Patient should not receive live vaccines such as oral polio, varicella, small pox, or nasal flu vaccine.
   iii. Patient should avoid contact with people who have been vaccinated with a live virus within the past 30 days

f. Miscellaneous
   i. Refrain from providing direct care for pets or farm animals.
   ii. Avoid contact with animal feces, saliva, litter box contents or barns.
   iii. Do not enter or travel through, construction/renovation or where construction material/debris has been placed or where fields have recently been plowed.

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

1. Infection Control Policy: Standard and Transmission Based Precautions

D. **REFERENCE(S):**

1. Oncology Nursing Society (2014).Chemotherapy Biotherapy Guidelines and Recommendations for Practice Third Edition.
2. Oncology Nursing Society (2016) PEP-Preventions of Infection.
3. Infectious Diseases Society of America (IDSA) to guide clinicians in the care of patients with chemotherapy and induced neutropenia and in the management of febrile neutropenia. http://cid.oxfordjournals.org/content/52/4/e56.full. (Reviewed 12/22)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Point-Of-Use Pre-Cleaning Of Reusable Instruments

REVISION DATE:

Patient Care Services Content Expert Approval:	05/22
Clinical Policies & Procedures Committee Approval:	~~06/22~~07/22
Nursing Leadership Approval:	07/22
Infection Control Committee Approval:	04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	04/23
Administration Approval:	05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To outline the process for point-of-use (POU) pre-cleaning of reusable instruments. Point-of-use pre-cleaning prevents the drying of blood, bodily fluids, and debris on reusable instruments, to prevent pitting and corrosion of instruments. Dried organic material can be difficult to remove from instruments and can prevent sterilization. Cannulated instruments and instruments with lumens can become obstructed with organic material during use. POU pre-cleaning improves the efficiency and effectiveness of decontamination and may extend the life of instruments.

B. **POLICY:**

1. Staff shall follow universal precautions and infection control principles when handling contaminated instruments, including wearing proper personal protective equipment (PPE).
2. Contaminated instruments should be handled in a manner that reduces the potential exposure of workers to disease-producing organisms and contamination of the environment.
3. Point-of-use pre-cleaning is to be completed at the bedside/in the procedure room before transport of soiled instruments to SPD decontamination area.
4. Gross soil should be removed as soon as possible to:
   a. Reduce the number of microorganisms on the instrument
   b. Reduce nutrient material that supports microbial growth
   c. Prevent drying of organic material on the instrument(s)
   d. Reduce the potential for environmental contamination by aerosolization or spillage
   e. Minimize corrosion risk and damage to instrument(s)
5. Sterile water should be used for instrument care during and immediately after use. Tap water and/or saline should not be used for instrument care as instrument damage can result.
6. All instruments opened in the procedure room should be considered contaminated, even if they were not used during the procedure, and therefore all opened instruments shall be pre-cleaned at the point of use.
7. To prevent damage to reusable instruments and avoid contamination of the environment, contaminated instruments shall be contained during transport. Transport containers shall be covered/closed and large enough to maintain the security and integrity of items being transported.
8. When the outside of a transport container or cart is visibly soiled, it should be decontaminated before transport.
9. Follow equipment/instrument manufacturer's instructions for use (IFU) for point-of-use pre-cleaning, as applicable.

C. **PROCEDURE:**

1. Bring POU pre-cleaning supplies to bedside/procedure area, including the following:
   a. Sterile water
   b. Red biohazard transport bin (with lid)
   c. Instrument transport gel/spray
2. During the procedure, wipe instruments with sterile water to remove gross soil.
3. Immediately after the procedure, at the point of use:
   a. Remove all disposable sharps (i.e., knife blades, needles) from the tray and dispose in appropriate sharps container, as applicable.
   b. Wipe down reusable instruments with sterile water to remove gross soil.
   c. Flush sterile water through cannulated instruments and instruments with lumens.
   d. Place reusable instruments in red biohazard transport bin, ensuring hinged instruments are in open position and multi-part instruments are disassembled.
   e. Spray instruments completely with transport gel/spray.
   f. Secure lid of red biohazard transport bin.
   g. Transport bin to SPD decontamination area.
4. SPD will clean the red biohazard transport bin and place in a plastic bag labeled "Clean".
   a. Units shall retrieve clean transport bins from SPD and return the bins to their respective Clean Utility areas for storage.
5. Unit-specific special considerations:
   a. Surgery:
      i. Instruments shall be pre-cleaned at the point of use and transported in enclosed case carts to SPD decontamination area via the designated Dirty Elevator.
      ii. Loaner instruments shall be pre-cleaned at the point of use and returned to original rigid containers (i.e., instrument pans), and completely covered for transport with a biohazard-labeled containment device.
   b. Women's and Newborn Services (WNS):
      i. Instruments used in the Labor and Delivery (L&D) Operating Room (OR) shall be pre-cleaned at the point of use and placed in an enclosed case cart.
         1) The case cart is stored in the Dirty Utility Room.
         2) The case cart of contaminated instruments shall be sent to SPD Decontamination area as soon as possible, and at a minimum, at least once per shift and if four (4) trays accumulate.
   c. Off-site clinics (including, but not limited to, Center for Wound Care and Hyperbaric Medicine and Outpatient Specialty Services Clinic):
      i. After point-of-use pre-cleaning, instruments that are completely covered in instrument transport gel/spray may be collected in a rigid, puncture-proof container with a lid and biohazard label.
      ii. Instruments shall be transported to SPD Decontamination area at the end of the each day.
      iii. Vehicles used for transporting contaminated items should provide for the complete separation of contaminated items from clean and sterile items. Because contamination of the vehicle could have occurred, transportation vehicles should be decontaminated between trips and after any spill.
      iv. Transportation personnel should receive training in basic infection prevention and control principles related to their responsibilities. PPE and biohazardous spill kit should be available in transportation vehicles.

D. **REFERENCE(S):**

1. ANSI/AAMI ST79:2017 Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	PUREWICK FEMALE URINARY INCONTINENCE MANAGEMENT
~~Purpose:~~	~~To identify the appropriate procedure for i~~ ~~management through implementation of t~~ ~~define the assessment, monitoring, and m~~ ~~management with implementation of the P~~
~~Supportive Data:~~	~~Reduces the need for inserting an indwelling urinary catheter for incontinent female patients and avoids the risk associated with catheter-associated urinary tract infections (CAUTI). Keeps patient's skin dry, avoids pressure injury, contact dermatitis from urine, and the need for diapers~~
~~Equipment:~~	~~PureWick System/ Female Urinary Incontinence system~~ ~~Wall suction regulator~~ ~~Suction canister and liner~~ ~~Suction tubing~~ ~~Suction tubing connectors~~ ~~Incontinence pads, patient undergarments, mesh panties (optional)~~ ~~Hygiene supplies~~

RETIRE – No longer use product, follow manufacturer's instruction for use on current product

~~A. **POLICY:**~~

~~1. Review the Elsevier Skill: Urinary Catheter: External Female for detailed information on the following:~~

~~a. Purpose~~

~~b. Assessment and Preparation~~

~~c. Procedure for application and removal~~

~~d. Monitoring and care~~

~~e. Expected and unexpected outcomes~~

~~2. Transport On and Off a Unit~~

~~a. Patients with PureWicks suction will be:~~

~~i. Disconnected from suction prior to transport by RNs and Advanced Care Technicians (ACTs)~~

~~ii. Reconnected to suction by RNs and ACTs when returning from test or procedures~~

~~B. **OBTAINING A URINE SAMPLE WITH THE PUREWICK:**~~

~~1. Set up suction~~

~~2. See Elsevier Skill: Specimen Collection: Midstream (Clean-Voided) Urine~~

~~a. While continuing to hold the labia apart,~~

~~i. Apply a female urinary incontinence device (do not connect to suction) have the patient initiate a urine stream, discard the female urinary incontinence device~~

~~ii. Apply a new female incontinence device, connect to suction and allow patient to void to collect a midstream specimen~~

~~iii. After collecting the midstream specimen, disconnect the suction tubing from the suction canisters, close the lids on the liner, and remove the liner.~~

~~1) If the female incontinence device is to remain in place, apply a new liner and connect the suction~~

~~2) If the female incontinence device is no longer require remove and discard suction tubing.~~

~~iv. Pour midstream specimen in a specimen container and label according to Patient Care Services Procedure: Specimen Labeling~~

~~v. Transport specimen to lab and document the collection in the~~

Department Review	Clinical Policies and Procedures Committee	Nursing Leadership	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/16,0 7/20, 10/21, **02/23**	01/17, 08/20, 10/21, **03/23**	02/17, 11/21, **04/23**	n/a	03/17, 11/21, **04/23**	11/21, **05/23**	04/17, n/a	04/17, 12/21

in the medical record

C. **TROUBLESHOOTING:**
1. If a large amount of urine is escaping from the gauze, contributing factors include but are not limited to:
   a. The gauze is not correctly tucked between the labia and buttocks.
      i. The gauze must be snugly positioned between the labia with the bottom end between the buttocks.
      ii. Ensure the top of the wick reaches just above the pubic bone.
      iii. Change the female external catheter i.e., PureWick
      iv. Apply mesh panties to assist with maintaining appropriate position
   b. No or low suction.
      i. Check suction settings and ensure the regulator is set to 40 mmHg
      ii. Check for kinks in the tubing or sediments
      iii. Ensure the suction canister lid is firmly in place
      iv. Verify the suction regulator is functioning
      v. Ensure the suction tubing is connected female insentience device tubing

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Specimen Labeling

E. **EXTERNAL LINK(S):**
1. Elsevier Skill: Specimen Collection: Midstream (Clean-Voided) Urine
2. Elsevier Skill: Urinary Catheter: External Female

F. **REFERENCE(S):**
1. PureWick, Inc. (2018, February). Instructions for use. Retrieved from https://www.bd.com/assets/documents/PDH/Initial/PF10741_BAW0319838.pdf
2. PureWick, Inc. (n.d.). Successful incontinence management for women. Retrieved from http://www.purewick.com/

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	05/92	SUBJECT:	Visiting Guidelines
REVISION DATE:	05/92, 09/94, 10/96, 01/99, 05/02, 05/03, 12/03, 12/05, 07/07, 02/09, 03/11, 07/14, 03/17, 05/20		

Patient Care Services Content Expert Approval:	~~02/20~~02/23
Clinical Policy & Procedures Committee Approval:	~~04/20~~03/23
Nursing Leadership Approval:	~~05/20~~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~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:
1. To promote patient and family focused care in a healing environment while maintaining patient and staff safety, privacy and infection control measures.

B. POLICY:
1. Visiting is determined by the healthcare needs of the patient.
   a. Family members/significant others are encouraged to participate in care planning through regular interaction with the patient and the health care team.
   b. Limitations may need to be made due to the clinical condition of the patient or at the patient's request.
2. Recognizing the positive contribution made by patients' family/significant others; the Medical Center is open for visiting 24 hours a day.
3. Special Considerations: Visiting hours may be restricted for medical or emergency situations. All exceptions or restrictions are at the discretion of the Chief Nurse Executive or designee.
   a. Adult supervision is required for children in all areas of the facility. Visitors under the age of 14 must be accompanied at all times by an adult other than the patient when visiting a patient unit.
   b. To provide privacy and confidentiality, visitors may be requested to wait in designated waiting areas during physician examinations, nursing care, and the performance of tests or procedures.
   c. In order to allow opportunity for medical care to be provided and to ensure adequate rest and privacy for patients.
      i. In rooms with adjoining beds (semi-private), 2 visitors per patient at a time are allowed.
   d. To ensure patient safety and infection control, family members/significant others and visitors are not allowed in the bed with a patient; nor allowed in an unoccupied patient care bed.
4. The following areas have special visiting policies. Visitors must check in at the nursing station in the following departments:
   a. Intensive Care Unite
   b. Women and Newborn Services
   c. Neonatal Intensive Care Unit
   d. Emergency Department

e. Surgical Services

5. Visitor responsibilities include but are not limited to:
   a. Observing the visiting hours for the area that they are visiting and leaving the patient room or care area when asked by hospital staff.
   b. Refraining from behavior that may cause annoyance, inconvenience and/or lack of consideration and assisting with the control of noise and the number of visitors.
   c. Consideration of the rights of patients and hospital staff by treating them with courtesy and respect.
   d. Maintenance of patient confidentiality and privacy.
   e. Refrain from damaging or removing any article or property belonging to TCMC.
   f. Refrain from bringing any food, alcohol or medications to the patient without prior approval from the physician.
   g. Reporting any concerns or complaints to the ~~Charge~~ Nurse **Leader~~,, Nursing Leadership~~** or designee.
   h. Use hand sanitizer or soap and water to wash hands.
6. Violent or aggressive behavior by visitors:
   a. The hospital will not tolerate violence or aggression by visitors towards staff, patients or other visitors.
   b. The following items and behaviors are prohibited at TCMC:
      i. Alcoholic beverages
      ii. Disruptive or violent behavior
      iii. Smoking/electronic smoking devices
      iv. Street drugs
      v. Weapons (see Administrative Policy: Weapons on Medical Center Campus 284)
   c. For the safety of our patients, visitors and staff - visitors who do not comply with safe conduct regulations may be asked to leave or will be escorted off hospital grounds.

C. **RELATED DOCUMENT(S):**
1. Administrative Policy: Weapons on Medical Center Campus 284

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
PATIENT CARE

ISSUE DATE:	06/83	SUBJECT:	Patients Injured by a Deadly Weapon or Criminal Act, Proper Handling of Evidence
REVISION DATE:	05/88, 09/91, 06/97, 06/03, 08/06, 06/09, 11/12, 03/19	POLICY NUMBER:	8610-315

Administrative Content Expert~~Department~~ Approval:	~~07/18~~08/22
Administrative Policies & Procedures Committee Approval:	~~08/18~~01/23
Environmental Health & Safety Committee Approval:	03/23
Pharmacy & Therapeutics Committee Approval:	n/a
~~Organizational Compliance Committee Approval:~~	~~n/a~~
Medical Executive Committee Approval:	~~02/19~~04/23
Administration Approval:	~~03/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. **PURPOSE:**

1. To ensure proper handling and preservation of evidence from a victim injured by a deadly weapon or criminal act. This includes maintaining chain-of-custody and storage and retrieval of any foreign objects removed from the patient.

B. **DEFINITION:**

1. Foreign Object: Any object, such as a knife or bullet that was used to inflict harm on or in a person.
2. Chain-of-Custody: A series of documented transfers of an evidentiary object listing the date, time and signature of the individual who has physically released custody of the object and of the individual who has physically received custody of the object. This documentation of each successful transfer of the object maintains the evidentiary chain of custody.

C. **POLICY:**

1. Process any clothing articles from victim of a violent crime as follows:
   a. Bag different clothing articles in different paper bags.
   b. Cut off clothing without going through a bullet or stab wound hole.
   c. Allow law enforcement authorities in the patient's room **Emergency Room** (ED) or **Operating Room** (OR) to collect evidence/take pictures from the victim.
   d. Allow law enforcement authorities (police or coroner) to complete picture taking and documentation prior to post mortem care.
2. Document wound size when doing assessment. Have a ruler available for measurements and for taking pictures.
3. Handling of Foreign objects; chain-of-custody:
   a. Bullets or other foreign objects removed from the victim may have legal consequences in the future.
   b. It is necessary that the chain of custody be maintained on these objects will be prepared, tagged and turned over to local law enforcement.
   c. All items will be placed in an envelope or other sealable container and labeled with the patient's name, medical record number, date and physician's name and will be

accompanied by a Property Custody Record.

d. If law enforcement authority is not present, notify Security for collection and complete Property Custody Record and After Action Incident Review forms.

e. The staff member who places the object in the envelope and seals it begins the chain-of-custody by logging on the form the date sealed and their signature. When passing on the envelope this person must sign, date the envelope and mark it "Released". The person who receives the envelope must sign, date and mark it "Received". Each transfer of the object must be logged in this way to create a chain-of-custody.

f. The object will be released to the custody of the law enforcement authority upon demand and proper identification. A business card or copy of photo ID of the officer receiving the object must be attached to the Property Custody Record form.

D. **FORM(S):**

~~1. Action Incident Review~~

~~2.~~**1.** Property Custody Record

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

1. Security Policy: Seized Contraband or Evidence 231
2. Security Policy: Security Incident Notification 208

Tri-City Medical Center

Allied Health Professional

Certified Nurse Midwife
Standardized Procedures

Approvals

OB/GYN Department (Date):	November 07, 2022
Interdisciplinary Practice Committee (Date):	January 16, 2023
Medical Executive Committee (Date):	~~April 27, 2020~~April 24, 2023
Administration Approval (Date)	May 15th, 2023
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	April 30, 2020~~4/30/20~~

NURSE PRACTITIONER STANDARDIZED PROCEDURES

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I. Development, Review and Approval of CNM Certified Nurse Midwife (CNM)Standardized Procedures
II. Setting and Scope of CNM Practice (Functions)
III. Management of Controlled Substances by the CNM
IV. Supervision of the CNM by Physician
V. CNM Qualifications – Education and Licensing
VI. Quality Improvement
~~VI.~~**VII. Practice Prerogatives**

I. DEVELOPMENT, REVIEW AND APPROVAL OF CNM STANDARDIZED PROCEDURES

A. Standardized procedures for the CNM are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the CNM to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF CNM PRACTICE (FUNCTIONS)

A. **SETTING**

1. The CNM may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The CNM is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF CNM PRACTICE (FUNCTIONS)**

1. The OB/GYN CNM will:
   a. Assume responsibility for the *OB/GYN* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the CNM with the agreement and under the supervision of the physician. The CNM must consult the supervising physician if assessing a medication outside of the CNM defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the CNM responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the CNM. Telephone orders are systems directed for physician

signature which is required within 48 hours.

c. Order medications as included in the OB/GYN Cerner Power Plans.
   i. The CNM will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonably foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
   ii. The CNM orders the medication and documents the information into the chart and in the clinical notes.
   iii. If a medication needed is not listed on a Power Plan the CNM must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co- signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an CNM does not require a standardized procedure.

e. Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the OB/GYN Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. ICNMatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of CNM care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve mental health care and patient outcomes.

m. Provide patient health education related to medications, psychiatric conditions and health issues.

C. The Nurse Practitioners will have access to the following Powerplans:
   1. OB GYN Pre-Operative Hold
   2. OB GYN Pre-Operative Education
   3. OB Pre-Op Teach Labs
   4. OB Tubal Ligation Pre/Intra Orders
   5. Discharge Women's
   6. OB 2016 L&D C-Section
   7. OB 2016 Postpartum C Section
   8. OB 2016 L&D Vaginal Delivery
   9. OB 2016 Tubal Ligation Pre/Intra Orders

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The CNM may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   2. When Schedule II through V drugs are furnished or ordered by a CNM, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of OB/GYN.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a CNM pursuant to California (CA) Business & Professions Code.
B. Each CNM will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four CNMs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the CNM and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
   1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   2. Acute exacerbation of a patient's situation;
   3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   4. Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
   5. Upon request of the patient, another clinician or Supervisor.
   6. Upon request of the CNM.
   7. The supervising physician will examine the patient on the same day as care is provided by the CNM for non-scheduled patient admissions.

V. CNM QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
B. Licenses and Certification:
   1. Current, valid RN license issued by the California Board of Registered Nursing
   2. Current, valid NM certificate issued by the California Board of Registered Nursing
   3. Current Furnishing Number issued by the California Board of Registered Nursing
   4. Current certification (or actively pursuing certification; must be certified within one year of initial appointment) by the American Midwifery Certification Board

(formerly the ACNM Certification Council, Inc.) College of Nurse Midwives
5. Current, valid NRP certificate
6. Current, valid DEA registration
7. Documentation of participation in relevant continuing education activities.

VI. QUALITY IMPROVEMENT

A. CNMs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The CNM will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The CNM will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. CNM cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the CNM's performance, and gives input into the Annual Performance Evaluation.
   5. The CNM will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The CNM will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. PRACTICE PREROGATIVES:

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

_____ _____
Nurse Practitioner Signature Date

_____ _____
Sponsoring Physician Signature Date

_____ _____
Sponsoring Physician Signature Date

_____ _____
Sponsoring Physician Signature Date

_____ _____
Sponsoring Physician Signature Date

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Emergency Medicine
Standardized Procedures

Approvals

Department of Emergency Medicine (Date):	April 12,2023
Interdisciplinary Practice Committee (Date):	April 17, 2023
Medical Executive Committee (Date):	April 24th, 2023
Administration (Date):	May 15th, 2023
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	

NURSE PRACTITIONER STANDARDIZED PROCEDURES

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I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
III. Management of Controlled Substances by the NP
IV. Supervision of the NP by Physician
V. NP Qualifications – Education and Licensing
VI. Quality Improvement
VII. Practice Prerogatives

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with the guidelines as required by the Board of Registered Nursing, Title 16, CCR Section 1474, and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privileges form. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. 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, competency, and supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
   a. *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:
      i. A treatment plan is developed based on appropriate history, assessment plus differential diagnosis and the resources listed in this document.
      ii. Lab work and diagnostic studies ordered are appropriate to the condition being evaluated.
      iii. 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.

b. *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:
   i. Assessment to the level of surety plus differential diagnosis.
   ii. A physician is communicated with regarding the evaluation, diagnosis and/or treatment plan.
   iii. 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.
   iv. The physician is notified if her/his name is used on a referral to a specialty physician or department.
   v. The consultation or referral is noted in the patient's chart including name of physician.
   vi. All Secondary Care charts are reviewed by and co-signed by a physician.
   vii. All other applicable Standardized Procedures in this document are followed during health care management.
   viii. All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

c. *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 <u>evaluate</u> Tertiary Care conditions under the following protocols:
   i. 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.
   ii. The referral is noted in the patient's chart including name of physician and/or entity referred to.

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of orthopedic surgery.

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

D. Medication evaluation includes the assessment of:

1. Other medications being taken.
2. Prior medications used for current condition.
3. Medication allergies and contraindications, including appropriate labs and exams.

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

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

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

H. Consultation with a physician, is noted in the patient's chart, including the physician's name.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
1. Additional Supervision occurs as described below under "Quality Improvement."

F. The NP will be managing primary, secondary and tertiary care conditions as outlined above. In addition, supervisor notification and consultation is obtained under the following circumstances:
1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
1. 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 (AANC)

B. Licenses and Certification:
1. License as a Nurse Practitioner by the State of California, Board of Registered Nursing; AND
2. Possession of a current California State-issued medication Furnishing Number; AND
3. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances; AND
4. Current BLS (Basic Life Support), ALS (Advanced Life Support) and PALS (Pediatric Advance Life Support) certifications.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. PRACTICE PREROGATIVES

A. As defined by the NP – Emergency Medicine Delineation of Privileges.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital, agree to maintain a collaborative and collegial relationship, agree to abide by the Standardized Procedures in theory and practice, and no physician hall provide concurrent supervision for more than four (4) NPs.

Nurse Practitioner Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner-Interventional Radiology Standardized Procedures

Approvals

Radiology Department (Date):	October 25, 2021
Interdisciplinary Practice (Date):	January 16, 2023
Medical Executive Committee (Date):	~~April 27, 2020~~April 24, 203
Administration (Date):	May 15th, 2023
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	April 30, 2020

NURSE PRACTITIONER STANDARDIZED PROCEDURES

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V. NP Qualifications – Education and Licensing
VI. Quality Improvement
~~VI.~~**VII. Practice Prerogatives**

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among ~~physiians~~**physicians**, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Interventional Radiology NP will:

~~2.~~**a.** Assume responsibility for the *Interventional Radiology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.

~~a.~~**i.** Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.

~~3.~~**b.** Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by

the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

~~4.~~**c.** Order medications as included in the Interventional Radiology Cerner Power Plans.

~~a.~~**i.** The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonably foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

~~b.~~**ii.** The NP orders the medication and documents the information into the chart and in the clinical notes.

~~c.~~**iii.** If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co- signature.

~~5.~~**d.** Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

~~6.~~**e.** Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

~~7.~~**f.** Order and interpret specific laboratory studies for the patient as included in the Interventional Radiology Power Plans.

~~8.~~**g.** Provide or ensure case management and coordination of treatment.

~~9.~~**h.** Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

~~10.~~**i.** Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

~~11.~~**j.** Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

~~12.~~**k.** Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

~~13.~~**l.** Formulate recommendations to improve mental health care and patient outcomes.

~~14.~~**m.** Provide patient health education related to medications, psychiatric conditions and health issues.

C. **THE NURSE PRACTITIONERS WILL HAVE ACCESS TO THE FOLLOWING POWERPLANS:**

1. Gastrostomy Tube Placement Order Set CITY v1
2. IR Chemoembolization CITY v1
3. IR Chest Tube Placement CITY v1
4. IR Dialysis Intervention CITY v1
5. IR G-JG Procedure CITY v1

6. IR Image Guided Biopsy/Fiducial Marker CITY v1
7. IR Image Guided Drainage CITY v1
8. IR Image Guided Lung Biopsy CITY v1
9. IR Paracentesis Thoracentesis CITY v1
10. IR Percutaneous GU/GI Drainage CITY v1
11. IR Port/Tunneled Catheter CITY v1
12. IR Stroke/Neurovascular Intervention CITY v1
13. IR TIPS CITY v1
14. IR Tube Check CITY v1
15. IR Vertebral Augmentation CITY v1
16. Paracentesis Orders CITY v1
17. PICC Insertion Request CITY v1
18. Thoracentesis Orders CITY v1

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
   a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Radiology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the

NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

1. Additional Supervision occurs as described below under "Quality Improvement."

F. Supervisor notification and consultation is obtained under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination or psychiatric evaluation and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:

1. Master's degree in Nursing from an accredited college or university; AND
2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:

1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
2. Currently certified by the State of California as a Nurse Practitioner;
3. Possession of a California State-issued medication Furnishing Number;
4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
5. BLS or ACLS in accordance with the specialty requirement.
6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.

1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.

1. Documentation of participation in relevant continuing education activities.

VII. PRACTICE PREROGATIVES

A. As determined by the NP – Interventional Radiology Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

_____ _____

Nurse Practitioner Signature Date

_____ _____

Sponsoring Physician Signature Date

_____ _____

Sponsoring Physician Signature Date

_____ _____

Sponsoring Physician Signature Date

_____ _____

Sponsoring Physician Signature Date

_____ _____

Sponsoring Physician Signature Date

Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Orthopedic & Spine Institute
Standardized Procedures

Approvals

Division of Subspecialty (Orthopedic Division) (Date~~)~~: October 13,2022

~~Surgery Department (Signature):~~

Interdisciplinary Practice Committee (Date): January 16, 2023

Medical Executive Committee (Date): ~~July 24, 2017~~April 24, 2023

Administration (Date): May 15th, 2023

Professional Affairs Committee (Date): n/a~~August 10, 2017~~

Board of Directors (Date): August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
III. Management of Controlled Substances by the NP
IV. Supervision of the NP by Physician
V. NP Qualifications – Education and Licensing
VI. Quality Improvement
VII. Practice Prerogatives

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Orthopedic & Spinal Institute NP will:
   a. Assume responsibility for the *Orthopedic & Spinal Institute* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Orthopedic division Cerner Power Plans.

i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.
ii. The NP orders the medication and documents the information into the chart and in the clinical notes.
iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
e. Obtain medical histories and perform overall health assessment for any presenting problem.
f. Order and interpret specific laboratory studies for the patient as included in the Orthopedic division Power Plans.
g. Provide or ensure case management and coordination of treatment.
h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
l. Formulate recommendations to improve patient outcomes.
m. Provide patient health education related to medications and health issues.
n. The PowerPlans for the Orthopedic Division are as follows:
   i. ORTHO Cervical Spinal Fusion Post Op Multi Phase
   ii. ORTHO Hip Fracture Post-Operative Multi Phase
   iii. ORTHO Lumbar Spinal Fusion Post Op Multi Phase
   iv. ORTHO Post-Operative
   v. ORTHO Pre-Operative
   vi. ORTHO Radiographs Lower Extremity
   vii. ORTHO Radiographs Upper Extremity
   viii. ORTHO Spine PostOp
   ix. ORTHO Spine PreOp

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.
B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled

substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the division of orthopedic surgery.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

1. Additional Supervision occurs as described below under "Quality Improvement."

F. Supervisor notification and consultation is obtained under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:

1. Master's degree in Nursing from an accredited college or university; AND
2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:

1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
2. Currently certified by the State of California as a Nurse Practitioner;
3. Possession of a California State-issued medication Furnishing Number;
4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
5. BLS or ACLS in accordance with the specialty requirement.
6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.

1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. PRACTICE PREROGATIVES

A. As determined by the NP – Orthopaedic & Spine Institute Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date

Tri-City Health Care District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS ~~Policy Manual~~

ISSUE DATE: 11/02

SUBJECT: Respiratory Protection

REVISION DATE~~(S)~~: 4/07; 9/08; 10/09, 10/12, 04/15

Employee Health Department Approval:	~~06/20~~03/23
Infection Control Committee Approval:	04/23
Environmental Health & Safety Committee Approval:	n/a
Medical Executive Committee Approval:	04/23
Administration Approval:	05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval	04/15

A. **INTRODUCTION:**

1. It is the policy of Tri-City Medical Center (TCMC) to provide employees with a safe and healthful working environment. This is accomplished by utilizing facilities and equipment that have all feasible safeguards incorporated into their design. When effective engineering controls are not feasible, or when they are being initiated, protections shall be used to ensure personnel protection.
2. Healthcare Workers should be required to use respiratory protection in situations and settings, where splashes or sprays of potentially infections materials are anticipated (e.g. ATD, bronchoscopies, and cough inducing procedures).
3. The requirements of this program are in accordance with Cal OSHA Aerosol Transmissible Diseases Standard, 29CFR 1910.134 and CCR Title 8, section 5144. Proper selection of respirators and administration of the Respiratory Protection Program shall be performed according to the guidance of ANSI (American National Standards Institute), 288.2-1980.
   a. *Registry staff are expected to have the OSHA requirements (related to tuberculosis, including education, and the respiratory protection program) fulfilled by their employers.

B. **RESPONSIBILITY:**

1. Employee Health Services (EHS) is ~~charged~~ **responsible** with establishing medical evaluation, surveillance procedures and reviewing the health status of all personnel who may be required to wear respiratory protective equipment in the completion of their assigned tasks.
   a. Employee Health shall initially, and at least annually thereafter, make a determination as to whether or not an employee can wear the required respirator without physical or psychological risk.
   b. Based on the ~~Quantitative~~ Respirator Questionnaire (Appendix A) and the overall health of the individual Employee Health or designee will determine~~s~~ whether or not the individual will be restricted from wearing respiratory protective equipment. If a medical restriction is applied, the employee and their supervisor are formally notified of the restriction.
   ~~a. Specific medical tests (for example, pulmonary function studies and EKG) and procedures will be determined by the Employee Health Nurse and the Occupational Health Medical Director, and will be in accordance with OSHA medical surveillance requirements and/or NIOSH recommendations.~~
   c. Environment of Care ~~Officer~~ **Manager** and/or Infection Preventionist will collaborate in the selection and use of respiratory protective devices.
   d. Employee Health or designee will~~,~~ conduct ~~quantitative~~ fit testing, and assist with the selection of necessary protective devices.
2. Supervisors and/or Managers shall be aware of tasks requiring the use of respiratory protection, and ensure all employees use the appropriate respirators at all times.
3. Supervisors and/or Managers will ensure each employee under his or her supervision-using

respirator has received appropriate training in its use and an annual evaluation.

4. Respirator Wearers: It is the responsibility of each respiratory wearer to wear his/her respirator when and where required and in the manner in which they were trained. Respiratory wearers must report any malfunctions of the respirator to his/her supervisor immediately. The respirator wearer must also guard against mechanical damage to the respirator, clean the respirator~~y~~ as instructed, and store the respirator in a clean, sanitary location.

C. **SELECTION AND USE OF RESPIRATORY PROTECTIVE DEVICES:**

1. Selection of the proper respirator(s) to be used in any work area at TCMC is made only after a determination has been made as to the real and/or potential exposure of employees to harmful concentrations of contaminants.
2. N95 respirators for our Tuberculosis and Aerosol Transmissible Disease Exposure Control Program are the most frequently used respiratory protection devices at TCMC. Powered Air Purifying Respirator (PAPR) will be used for respiratory protection when the N95 is not suitable.
3. The following items will be considered in the selection of respirators:
   a. Effectiveness of the device against the substance of concern;
   b. Estimated maximum concentration of the substance in the work area;
   c. General environment (e.g. open shop or confined space);
   d. Known limitations of the respiratory protective device;
   e. Comfort, fit, and worker acceptance; and
   f. During high risk activities on known ATD (e.g. cough inducing procedures, bronchoscopies, and aerosol generating procedures).
   g. Other contaminant in the environment or potential for oxygen deficiency.
4. No attempt will be made to fit a respirator on an employee who has facial hair which comes between the sealing periphery of the face-piece and the face, or if facial hair interferes with normal functioning of the exhalation valve of the respirator. These employees and those who must enter a TB isolation room but have not been fit tested will utilize Powered Air Purifying Respirators (PAPR)
5. Proper fitting of a respiratory protective device face-piece for individual wearing corrective eyeglasses or goggles may not be established if temple bars or straps extend through the sealing edge of the face-piece. If eyeglasses, goggles, face shield, or welding helmet must be worn with a respirator, they must be worn so as not to adversely affect the seal of the face-piece.
6. Respirator use is authorized and issued for ~~the following~~ personnel **as determined by Employee Health Services and Infection Control.**
   ~~a. Job classification to comply with mandatory annual respirator training and fit testing related to Aerosol Transmissible diseases such as Tuberculosis. See Appendix C~~

D. **RESPIRATORY TRAINING:**

1. The training program will include the following:
   a. N95 Respirator Training
   b. Donning procedures and fit tests including hand's-on practice
   c. Care of the respirator (e.g., need for cleaning, maintenance, storage, and/or replacement of reusable equipment)
   d. Use and limitations of respirator
2. Respirator users and their supervisors will receive training on the contents of TCMC's Respiratory Protection Program and their responsibilities.
3. Employee Health or designee provides training of respirator wearers in the use, maintenance, capabilities, ~~and~~ limitations of respirators **and**~~are~~ initially upon assignment of personnel to tasks requiring the use of respirators.
4. Retraining is given annually thereafter and only upon successful completion of the medical evaluation. (See Appendix A)
5. Respirator training will be properly documented and will include type and model of respirator for which the individual has been trained and fit-tested.

E. **RESPIRATOR FIT TESTING:**

1. A ~~quantitative~~ fit test shall be used to determine the ability of each individual respirator wearer to obtain a satisfactory fit with the disposable N95 particulate respirator. Personnel must successfully pass the fit test before being issued a respirator. No TCMC employee is permitted to

wear a respirator in a work situation until he or she has demonstrated that an acceptable fit can be obtained.

F. **RESPIRATOR USER CERTIFICATES/CARDS:**

1. Respirator User Certificates/Cards will be issued to workers who have been trained, fitted, and medically evaluated to use respirators. The Respirator User Certificate will include:
   a. Name of the worker.
   b. The statement: "(name) has been trained, fitted and medically evaluated to use the respirator(s) indicated."
   c. The type(s), model(s), and size(s) of respirator(s) that the employee was issued.
   d. Date of certificate.

G. **RECORD KEEPING:**

1. Employee Health or designee will maintain employee records that include the respirator fit testing. The following shall be documented in the records:
   a. Type of respirator
   b. Brand name and model
   c. Method of test and test results
   d. Test date
   e. Name of the instructor/tester

~~H.~~ ~~**APPROVALS**~~

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

H. **RELATED DOCUMENTS:**

~~2.~~**1. Aerosol Transmissible Diseases and Tuberculosis Control Plan**
2. Injury/Illness Prevention Program

I. **~~RE~~FERENCES:**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities, **December 30,** 2005~~4.~~
2. ~~. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=Standarp S&p_id=9780 10/2010~~
3. TB Respirator Protection Program in Health Care Facilities. DHHS (NIOSH) Publication No. 99-143. ~~http://www.osha-slc.gov/SLTC/respirator_advisor/oshafiles/otherdocs.html~~ **https://www.cdc.gov/niosh/topics/tb/respprotection.html**
4. ~~Injury Prevention Program, 8610-401~~
4. ~~www.cdc.gov/topics/respirators 12/2014~~
5. **TCMC policy:** Aerosol Transmissible Diseases and Tuberculosis Control Plan, IC.11
6. ~~Cal OSHA Aerosol Transmissible Diseases Standard, 29CFR 1910.134~~
7. CCR Title 8, section 5144 **https://www.dir.ca.gov/title8/5199.html**
8. **Implementing Respiratory Protection Programs in Hospitals: CDPH Occupational Health Branch: August 2015**
9. **https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf**
10. **Cal/OSHA's Aerosol Transmissible Disease Standards and Local Health Departments: ~~O~~ccupational Health Branch: CDPH, January 2018**

~~2.~~

Tri-City Medical Center
Employee Health Services
4002 Vista Way • Oceanside • CA • 92056
T) 760.940.7270 • F) 760.940.4005 • Mon.-Fri. 7:30am-4:00pm

Quantitative Respirator Questionnaire

This questionnaire is used to assist in determining whether you have a medical condition that may affect your ability to wear a respirator. In some cases, we may ask for more information than is on the questionnaire. In some cases, we may ask for more information than is on the questionnaire. This form must be completed prior to testing and all information must be completed for respirator approval.

Name:	**Employee ID Number:**	**Department**

Medical History			**Review of Symptoms**		
Has a doctor ever told you that you had any of the following?	Yes	No	Have you ever experienced any of these symptoms?	Yes	No
Angina			Are you short of breath at rest?		
Heart Attack			Do you become short of breath when walking?		
Lung Disease (emphysema, asthma, chronic bronchitis, COPD, etc.)			Do you get chest pain with certain activities?		
Do you have medical problems that might interfere with respirator use?			Have you ever had problems that might interfere with respirator use?		
Smoking History			Do you have a sensation of smothering or claustrophobia when wearing a mask?		
			Have you had a significant weight loss or gain, facial surgery/trauma since you were last fit tested?		
			Men Only: have you grown a beard or goatee in the past year?		

Explain Yes answers:

☐ I acknowledge that if I was unable to be fit tested, I will be required to wear a Positive Air Pressure Respirator (PAPR).

Signature:	**Date:**

Employee Health Services Use Only

Fit Test Results
☐ Pass
☐ Fail
Mask Size:
☐ Small
☐ Regular
Brand Mask Used
☐ 3M
☐ Kimberly Clark

Signature:	**Date:**

~~03/2015~~

Tri-City Medical Center
Employee Health Services
4002 Vista Way • Oceanside • CA • 92056
T) 760.940.7270 • F) 760.940.4005 • Mon.-Fri. 7:30am-4:00pm

QUANTITATIVE RESPIRATOR QUESTIONNAIRE

This questionnaire is used to assist in determining whether you have a medical condition that may affect your ability to wear a respirator. In some cases, we may ask for more information than is on the questionnaire. This form must be completed prior to testing and all information must be completed for respirator approval.

PRINT NAME:_____ **EMPLOYEE ID#:**_____**DEPARTMENT:**_____

Medical History			**Review Of Symptoms**		
Has a doctor ever told you that you had any of the following?			**Have you ever experienced any of these symptoms?**		
Angina	Yes	No	Are you short of breath at rest?	Yes	No
Heart attack	Yes	No	Do you become short of breath when walking?	Yes	No
Lung Disease (emphysema, asthma, chronic bronchitis, COPD, etc)	Yes	No	Do you get chest pain with certain activities?	Yes	No
Do you have medical problems that might interfere with respirator use?	Yes	No	Have you ever had problems that might interfere with respirator use?	Yes	No
Smoking History	Yes	No	Do you have a sensation of smothering or claustrophobia when wearing a mask?	Yes	No
			Have you had a significant weight loss or gain, facial surgery/trauma since you were last fit tested?	Yes	No
			Men Only: Have you grown a beard or goatee in the past year?	Yes	No
Explain " Yes" answers:					

I acknowledge that if I was unable to be fit tested, I will be required to wear a Positive Air Pressure Respirator (PAPR).
I acknowledge that it is my responsibility to contact Employee Health Services for Positive Air Pressure Respirator (PAPR) training.

Employee Signature: **Date:**

*****EMPLOYEE HEALTH SERVICES USE ONLY*****	
FIT TEST RESULTS: ____Passed Test ____Failed Test (Needs PAPR training) ____PAPR Training completed	**Manufacturer: 3M / Style: N95** **MASK SIZE:** ___1860S (Small) ___1860 (Regular)
Trainer Signature: **Date:**	

Revised 05/19

~~**Appendix C**~~
~~**Tri-City Medical Center**~~

~~Job Classifications Required to Comply with Respirator Training and Fit-Testing Related to Aerosol Transmissible Diseases including Tuberculosis~~

~~Certified Nurses Assistant/ACT including Home Health Services~~

~~Case Managers/Social Services Staff~~

~~EKG Tech~~

~~Environmental Services Aide~~

~~Emergency Technician/Mental Health Workers~~

~~Laboratory Assistant/Phlebotomist~~

~~LVN~~

~~OR Tech~~

~~Operations Manager/Shift Supervisors~~

~~Respiratory Equipment Tech~~

~~Radiology Tech; MRI Tech; CT Tech~~

~~Registered Nurse including Home Health Services~~

~~Respiratory Therapist~~

~~NICU staff including Occupational and Physical therapists~~
~~Home Health Occupational and Physical Therapist~~

~~Security Officers~~

~~Transporter/Lift Team~~

~~Plant Management~~

~~Access Management Representatives – Emergency Department~~

~~New Born Hearing Screener~~

~~Anesthesia Tech~~

~~Perfusionist~~

Tri-City Medical Center
Employee Health Services
4002 Vista Way, Oceanside, CA 92056
T) 760-940-7270 I Fax: 760-940-4005
Office Hours: Monday –Friday 7:30 a.m. – 4:00 p.m.

RESPIRATOR QUESTIONNAIRE

This questionnaire is used to assist in determining whether you have a medical condition that may affect your ability to wear a respirator. In some cases, we may ask for more information than is on the questionnaire. This form must be completed prior to testing and all information must be completed for respirator approval.

PRINT NAME:_____ DATE OF BIRTH: _____

EMPLOYEE ID#:_____JOB TITLE:

_____DEPT:_____

Medical History			Review Of Symptoms		
Has a doctor ever told you that you had any of the following?			Have you ever experienced any of these symptoms?		
Angina	Yes	No	Are you short of breath at rest?	Yes	No
Heart attack	Yes	No	Do you become short of breath when walking?	Yes	No
Lung Disease (emphysema, asthma, chronic bronchitis, COPD, etc)	Yes	No	Do you get chest pain with certain activities?	Yes	No
Do you have medical problems that might interfere with respirator use?	Yes	No	Have you ever had problems that might interfere with respirator use?	Yes	No
Smoking History	Yes	No	Do you have a sensation of smothering or claustrophobia when wearing a mask?	Yes	No
			Have you had a significant weight loss or gain, facial surgery/trauma since you were last fit tested?	Yes	No
			Men Only: Have you grown a beard or goatee in the past year?	Yes	No
Explain " Yes" answers:					

I acknowledge that if I was unable to be fit tested, I will be required to wear a Positive Air Pressure Respirator (PAPR).
I acknowledge that it is my responsibility to contact Employee Health Services for Positive Air Pressure Respirator (PAPR) training.

Employee Signature: Date:

*****EMPLOYEE HEALTH SERVICES USE ONLY*****	
FIT TEST RESULTS: _____Passed Test _____Failed Test (Needs PAPR training) _____PAPR Training completed	Mask Type And Size: _____3M N95 1860S (Small) _____3M N95 1860 (Regular) _____3M AURA Particulate Respirator 9205+ , N95 Other: _____
Trainer Signature:	Date:

Respirator Questionnaire Revised 10/2020

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~POLICY MANUAL~~

ISSUE DATE: 08/16 **SUBJECT:** Bed Bugs, Identification and Control

REVISION DATE~~(S)~~: 12/19

Department Approval:	~~09/19~~12/22
Infection Control Committee Approval:	~~10/19~~04/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/19~~04/23
Administration Approval:	~~11/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **DEFINITION:**
1. Bed bugs (Cimex lectularius): small, flat, wingless, parasitic insects that feed solely on the blood of people and animals while they sleep.
   a. Adult bed bugs are 5-6mm (1/4 inch) & reddish brown in color, while young bed bugs are 1mm-4mm (1/16"-1/4") & translucent.
   b. Bed bugs do not transmit disease. Bed bug bites will cause red, raised itchy, reactions on the skin. Scratching can lead to secondary skin infections. Bed bugs are moved from infested areas to non-infested areas on clothing, luggage, furniture, or bedding. They hide during the day in places such as seams of mattresses and box springs, bed frames, dresser, tables and cracks and crevices or objects around the bed. Bed bugs can live several months without a blood meal.

B. **PURPOSE:**
1. Provide assistance in identifying and controlling bed bug infestation.

C. **POLICY:**
1. Movement of the patient to other areas of the hospital should be limited.
   a. Use disposable suit to provide containment as needed for infestations during transport throughout facility

D. **PROCEDURE:**
1. While in the Emergency Department (ED):
   a. Place patient in Contact Precautions upon realizing or suspecting the patient has bed bugs.
   b. Examine the patient to determine if bed bugs are present.
   c. Place patient in clean gown and linens upon orders for inpatient admission.
   d. Bag up all personal clothing & belongings and seal the bag tightly. Keep sealed until the patient is discharged. If the patient is being admitted, send clothes and personal belongings home with family if possible.
   e. Contact Environmental Services (EVS) to clean the room once patient has been discharged from bed space. Inform EVS room may have contained bed bugs.
2. Upon inpatient admission:
   a. Continue Contact Precautions.
   b. Continue to keep all clothes and personal belongings sealed tightly. Send clothes and personal belongings with family if possible.

c. Have the patient shower if possible.
d. Place work order to notify Building Engineering once patient has been admitted to the room. Include the reason: potential bed bug infestation and will need to have pest control inspection once patient has been discharged from room.

3. Upon discharge:
   a. Once patient is discharged notify Building Engineering so they can contact Pest Control to inspect room.
   b. Once the room is cleared through Building Engineering (& Pest Control), contact EVS to have room terminally cleaned.

E. **REFERENCE LIST:**

1. http://www.cdc.gov/parasites/bedbugs/faqs.html
2. https://www.cdc.gov/parasites/bedbugs/health_professionals/index.html

NYMPHS, OR BABY BED BUGS, ARE SLIGHTLY SMALLER AND NEARLY COLORLESS WHEN THEY FIRST HATCH, BECOMING DARKER AS THEY MATURE. ADULT BED BUGS DO NOT FLY, BUT CRAWL WHEN SEEKING REFUGE OR A HOST.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/98 **SUBJECT: Construction**

REVISION DATE~~(S)~~: 04/01, 06/03, 4/07, 10/07, 10/13, 08/16, 12/19

Infection Control Department Approval:	~~09/19~~12/22
Infection Control Committee Approval:	~~10/19~~04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/19~~04/23
Administration Approval:	~~11/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **INTRODUCTION:**

1. Multiple published studies have linked healthcare associated infection with the dispersal of microorganisms during construction. Planning is required prior to construction, renovation and repair projects that are expected to generate moderate to high levels of dust or require demolition or removal of any fixed building components and systems as well as new construction projects to assure patient and staff safety. A multidisciplinary team approach will be used.

B. **PURPOSE:**

1. The intent of this policy is to minimize infection risks to patients, staff, volunteers and the public that may arise as a result of exposure to organisms released into the environment during maintenance, construction and renovation activities. The matrix grid format adopted by our facility identifies the number and types of controls and Infection Control interventions necessary to protect patients and decrease dust generation.

C. **PROCEDURE:**

1. Infection Prevention is included early in the planning of construction and renovation projects.
2. Engineering will collaborate with other department leaders in the planning phase as needed depending on the scope of the project.
3. Engineering and Infection Prevention will review the scope of the planned construction, renovation and /or repair. An assessment of infection exposure risk will be documented on the Infection Control Risk Assessment (ICRA): Infection Control Construction Permit prior to beginning the work.
4. All construction workers, including subcontractors and hospital staff must follow the infection control procedures described in this policy.
5. Expansion or change in scope of the project requires re-assessment and a revision of the ICRA.

D. **ENGINEERING:**

a. Assist in the coordination of efforts by completing the Assessment of the Impact of Construction Projects prior to or during early planning meetings with the Area Director. The Assessment of the Impact of Construction Projects will be filled out for projects that require a building permit and other high-risk projects as determined by Director of Engineering or designee.

b. Review infection control measures prior to construction with the staff and contract workers. Explain expectations to contractors. Ensure that infection control policies are

followed during the construction.

c. Direct traffic away from the construction site.

d. Notify the Infection Preventionist and the Safety Officer if mold is encountered during a construction/renovation project and implement precautions in Infection Control Policy: Mold Abatement IC 13.3.

e. To isolate renovation areas from occupied areas, use airtight barriers. Ensure that barriers are fire retardant and sealed tightly.

f. Construction or renovation projects that fall into the Class III or IV category will have containment performed by qualified personnel. See Infection Control Construction Permit (ICRA) Form).

g. Adequate window seals should be installed and maintained to prevent outside air from entering the room.

h. Reusable barrier cubes are cleaned after each use. Take outside and hose off both the inside and outside of the container. Spray and wipe with hospital-approved disinfectant and allow the plastic to air dry.

i. After completion of construction, contractor will perform construction clean-up.

j. Engineering will notify Environmental Services to perform a terminal clean and disinfection of the involved area prior to placing back into service.

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

1. Infection Control & Construction Fact Sheet for Employees and Patients
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
3. Infection Control Policy: Healthcare Associated Infections, Defined
4. Infection Control Policy: Mold Abatement
5. Infection Control Policy: Surveillance Program

E. **FORM(S):**

1. Assessment of the Impact of Construction Projects
2. Infection Control Construction Permit (ICRA)

F. **REFERENCE(S):**

1. Bartley, J.M., APIC State of the Art Report: The role of infection control during construction in healthcare facilities. Am J Infect Control 2000; 8 156-69.
2. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2008. On-line at APIC.com
3. Infection Prevention Manual for Construction & Renovation: APIC 2015
4. Cotten, B., (2014) APIC Text of Infection Control & Epidemiology (4th ed): Construction & Renovation Chapter 116

Infection Control Construction Permit

Description:	Permit No:
Location of Construction:	Project Start Date:
Project Coordinator:	Estimated Duration:
Contractor Performing Work:	Permit Expiration Date:
Superintendent/Supervisor:	Telephone:

YES	NO	CONSTRUCTION ACTIVITY
		TYPE A: Inspection, non-invasive activity
		TYPE B: Small scale, short duration, moderate to high levels dust
		TYPE C: Activity generates moderate to high levels of dust, requires greater 1 work shift for **completion**
		TYPE D: Major duration and construction activities Requiring consecutive work shifts

YES	NO	INFECTION CONTROL RISK GROUP
		GROUP 1: Office areas, Storage rooms without patient care equipment, unoccupied areas
		GROUP 2: Cardiac/Pulmonary Rehab, Linen storage areas, Outpatient areas, patient waiting areas
		GROUP 3: Emergency room, Imaging/MRI, PACU/SPRA, Postpartum, Newborn nursery, Nuc med, Kitchen/Cafeteria, All Medical units except those in Group 4, Medication rooms, Pharmacy
		GROUP 4: Negative pressure rooms

Circle appropriate level	Type A	Type B	Type C	Type D
Group 1	Level I	Level II	Level II	Level III/IV
Group 2	Level I	Level II	Level III	Level IV
Group 3	Level I	Level II	Level III/IV	Level IV
Group 4	Level II	Level III/IV	Level III/IV	Level IV

Level I

1. Execute work by methods to minimize raising dust from construction operations.
2. Immediately replace any ceiling tile displaced for visual inspection.
3. Minor Demolition for Remodeling

Level II

1. Provides active means to prevent air-borne dust from dispersing into atmosphere
2. Water mist work surfaces to control dust while cutting.
3. Seal unused doors with duct tape.
4. Block off and seal air vents.
5. Wipe surfaces with cleaner/disinfectant.
6. Contain construction waste before transport to trash in a tightly covered containers.
7. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area.
8. Place dust mat at entrance and exit of work area.
9. Isolate HVAC system in areas where work is being performed; restore when work completed.

Level III

1. Obtain infection control permit before construction begins.
2. Isolate HVAC system in area where work is being done to prevent contamination of the duct system.
3. Complete all critical barriers or implement control cube method before construction begins.
4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units.
5. Do not remove barriers from work area until complete project is checked by Infection Prevention & Control and thoroughly cleaned by Environmental Services.
6. Vacuum work with HEPA filtered vacuums.
7. Wet mop with cleaner/disinfectant
8. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.
9. Contain construction waste before transport in tightly covered containers.
10. Cover transport receptacles or carts. Tape covering.
11. Upon completion, restore HVAC system where work was performed.

Date

Initial

Level IV

1. Obtain infection control permit before construction begins.
2. Isolate HVAC system in area where work is being done to prevent contamination of duct system.
3. Complete all critical barriers or implement control cube method before construction begins.
4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units.
5. Seal holes, pipes, conduits, and punctures appropriately.
6. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site.
7. All personnel entering work site are required to wear shoe covers.
8. Do not remove barriers from work area until completed project is checked by Infection Prevention & Control and thoroughly cleaned by Environmental. Services.
9. Vacuum work area with HEPA filtered vacuums.
10. Wet mop with disinfectant.
11. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction.
12. Contain construction waste before transport in tightly covered containers.
13. Cover transport receptacles or carts. Tape covering.
14. Upon completion, restore HVAC system where work was performed.

Date

Initial

Facilities Safety Officer: Date:	Infection Preventionist: Date:
Project Coordinator: Date:	Supervisor of Department affected by construction activity: Date:

TRI-CITY MEDICAL CENTER
Pre-Construction and Infection Control Risk Assessment

Location of Construction:	Project Start Date:
Project Coordinator:	Estimated Duration:
Contractor Performing Work:	Permit Expiration Date:
Supervisor:	Telephone:

Description of project:

Construction Activities

The following projects do not require completion of the pre-construction risk assessment form:

1. Paint and wallpaper in business offices and non-patient areas.
2. Paint in patient room if closed for painting and less than 3 sq.ft. of wall needs patched. Filter for room unit changed after painting.
3. Installation of soap dispenser/needle box/paper towel holder/etc. in patient room except in a Protective Isolation room or if the patient is out of the immediate area and clean-up can be accomplished before the patient returns.
4. Repair of window blind.
5. Ceiling tile replacement for areas less than 10 2 X 2 tiles, if in business offices and non-patient areas.
6. Ceiling tile replacement for area less than 5 2 X 2 tiles in a patient area if patient is out of the immediate area and clean up can be accomplished before patient returns.
7. Minimum repair of nurse call system/TV/Bed/Telephone.
8. Check or replace electric outlet.
9. Replace light bulb.
10. Unstop sink/commode with no water on floor.
11. Unstop commode when water on floor requires Plant Engineering to have Environmental Services clean area immediately.
12. Repair medical gas outlet. (Front Body)
13. Air balance readings.
14. Check air-conditioning if doesn't generate dust and debris.

General

Yes No

☐ ☐ Will there be noise generated that will impact a department adjacent to, above, or below the construction area?
   a. If so, these departments must be notified.
   b. How will noise be reduced to an acceptable level?

☐ ☐ Will there be vibration generated that will impact a department adjacent to, above, or below the construction area?
   a. If so, these departments must be notified each time this type of work will be performed.
   b. How will vibration be reduced to an acceptable level?

☐ ☐ Are Emergency Procedures in place for accidental events that could greatly impact Patient Care or Life Safety to the facility? Included in these procedures are such things as:
   - Emergency telephone numbers of key departments.
   - A plan that describes where main valves, switches, and controls are for the area in case of an emergency.
   - A plan for unexpected outages.

Environment

Yes No

☐ ☐ Will hazardous chemicals be used on this project? How will fumes and odors be controlled? Safety Data Sheets are required for all hazardous chemicals used on the project.

☐ ☐ Is hazardous material abatement required on this job? If so, notify Facilities.

☐ ☐ Will there be hot work done on this project? If there is, then a hot work permit must be posted on the job site. All hot work requires an assessment and may require a fire watch pursuant to NFPA 51B.

Utilities

Yes No

Will any of the following systems be out of service at any time during the project?

☐ ☐ Fire alarm (If out for more than 4 hours, Interim Life Safety Measures must be implemented.)

☐ ☐ Sprinkler (If out for more than 4 hours, Interim Life Safety Measures must be implemented.)

☐ ☐ Electrical

☐ ☐ Domestic water

☐ ☐ Medical Gases

☐ ☐ Sewage

☐ ☐ HVAC

Emergency Procedures and ILSM

Yes No

☐ ☐ Will there be any work that may require activation of the Interim Life Safety Measures during this project? If the answer to this question is yes, contact Facilities immediately to evaluate need for area training. Some things that may require ILSM's to be implemented are but not limited to:

- ☐ Any construction that impacts an exit or stairs
- ☐ Any construction that impacts major breaches in a fire or smoke wall
- ☐ Taking the main fire protection system out of service (sprinkler)
- ☐ Taking the main fire alarm system out of service
- ☐ Taking the "area" fire or fire alarm systems out of service for more than 4 hours within a 24-hour period.

Implementation of the ILSM requires the ILSM form to be completed and may require a fire watch.

Additional Safety Concerns

Yes No

☐ ☐ Will construction affect exit routes from occupied areas adjacent to construction site?

☐ ☐ Will project affect traffic patterns in area? If yes, explain plan.

Air Quality and Infection Control

The construction activity types are defined by the amount of dust that is generated, the duration of the activity, and the amount of shared HVAC systems. Contact the Infection Prevention Department if any activity is questionable under these guidelines.

Yes No

☐ ☐ Will dust be generated during this project? If yes, explain location of and plan for interim dust barriers or attach floor plan with barriers clearly marked.

☐ ☐ Will debris removal be necessary? If yes, explain plan for debris removal and control.

☐ ☐ Will work be done in a sterile area? If so, how will a sterile atmosphere be maintained in work area and access to and from work area?

Infection Control Classification

Step 1 – Identify the Construction Activity Type

Type A Inspection and non-invasive activities or small scale, short duration activities do not generate appreciable dust and do not require cutting of walls or access to ceilings other than for visual inspection, including, but not limited to:

Yes No

☐ ☐ Removal of ceiling tiles for visual inspection limited to 1 tile per 50 square feet

☐ ☐ Painting (but not sanding)

☐ ☐ Wall covering

☐ ☐ Electrical trim work

☐ ☐ Minor plumbing

☐ ☐ Installation of telephone and computer cabling in non-patient care areas

Type B Small scale, short duration activities that create minimal dust, including, but not limited to:

Yes No

- ☐ ☐ Installation of telephone and computer cabling in patient care area
- ☐ ☐ Access to chase spaces
- ☐ ☐ Cutting of walls or ceiling where dust migration can be controlled

Type C Any work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies (e.g., countertops, cupboards, sinks), including but not limited to:.

Yes No

- ☐ ☐ Sanding of walls--drywall finishing for painting or wall covering
- ☐ ☐ Removal of floor coverings, ceiling tiles, or casework
- ☐ ☐ Cutting of walls or ceiling
- ☐ ☐ New wall construction
- ☐ ☐ Minor ductwork or electrical work above ceilings
- ☐ ☐ Major cabling activities
- ☐ ☐ Any activity that cannot be completed within a single work shift

Type D Major demolition and construction projects, including, but not limited to:.

Yes No

- ☐ ☐ Activities that require consecutive work shifts
- ☐ ☐ Will require heavy demolition or removal of a complete ceiling system (Appendix 3 said cabling systems but I believe that ceiling system is correct)
- ☐ ☐ New construction

STEP 1: Type: _____

Step 2 – Identify the Patient Risk Groups Affected by the Work

Using the following table, *identify* the Patient Risk Groups that will be affected by the work. For example, include areas that are adjacent to the site or are in areas where vibration may cause fallout on the rooms beneath the site. Note: This list is not all inclusive. It provides examples of types of patient care areas.

Low Risk	Medium Risk	High Risk	Highest Risk
• Office areas • Public areas (e.g., lobbies)	• Outpatient Clinics (except transplant and oncology) • Cafeterias • Public Corridors	• All inpatient nursing units that are not ICUs or Step-down units. • Emergency Room • Labor & Delivery • Laboratories • Pharmacy • PACU • Food preparation/food service areas • Cardiology • Echocardiography • Endoscopy • Nuclear Medicine • Physical Therapy	• **Any inpatient area housing immuno-compromised patients:** o ICU, NICU, Oncology [2P], • Step-down Units • Cardiac Cath Lab • Dialysis • Sterile Processing • Negative pressure isolation rooms • Operating rooms, including C-section rooms and Outpatient Surgery • PACU • Oncology clinics and infusion areas

Emergency Procedures and ILSM

Yes No

☐ ☐ Will there be any work that may require activation of the Interim Life Safety Measures during this project? If the answer to this question is yes, contact Facilities immediately to evaluate need for area training. Some things that may require ILSM's to be implemented are but not limited to:

- ☐ Any construction that impacts an exit or stairs
- ☐ Any construction that impacts major breaches in a fire or smoke wall
- ☐ Taking the main fire protection system out of service (sprinkler)
- ☐ Taking the main fire alarm system out of service
- ☐ Taking the "area" fire or fire alarm systems out of service for more than 4 hours within a 24-hour period.

Implementation of the ILSM requires the ILSM form to be completed and may require a fire watch.

Additional Safety Concerns

Yes No

☐ ☐ Will construction affect exit routes from occupied areas adjacent to construction site?

☐ ☐ Will project affect traffic patterns in area? If yes, explain plan.

Air Quality and Infection Control

The construction activity types are defined by the amount of dust that is generated, the duration of the activity, and the amount of shared HVAC systems. Contact the Infection Prevention Department if any activity is questionable under these guidelines.

Yes No

☐ ☐ Will dust be generated during this project? If yes, explain location of and plan for interim dust barriers or attach floor plan with barriers clearly marked.

☐ ☐ Will debris removal be necessary? If yes, explain plan for debris removal and control.

☐ ☐ Will work be done in a sterile area? If so, how will a sterile atmosphere be maintained in work area and access to and from work area?

Infection Control Classification

Step 1 – Identify the Construction Activity Type

Type A Inspection and non-invasive activities or small scale, short duration activities do not generate appreciable dust and do not require cutting of walls or access to ceilings other than for visual inspection, including, but not limited to:

Yes No

☐ ☐ Removal of ceiling tiles for visual inspection limited to 1 tile per 50 square feet

☐ ☐ Painting (but not sanding)

☐ ☐ Wall covering

☐ ☐ Electrical trim work

☐ ☐ Minor plumbing

☐ ☐ Installation of telephone and computer cabling in non-patient care areas

Step 3 **– Complete the Infection Control Matrix to Determine the Class of Precautions. Class III and IV jobs lasting more than two weeks require solid, not plastic, barriers. Class II jobs may require a solid barrier, as recommended by Infection Prevention and Facilities.**

Match **the Patient Risk Group (Low, Medium, High, Highest) with the planned Construction Project Type (A, B, C, D) on the following matrix to find the Class of Precautions (I, II, III, or IV) or level of infection control activities required.**

	CONSTRUCTION ACTIVITY *Check type of activity*		**INFECTION CONTROL RISK GROUP** *Check risk group*
☐	TYPE A: Inspection, non-invasive activity	☐	GROUP 1: Low Risk
☐	TYPE B: Small scale, short duration, moderate to high levels of dust	☐	GROUP 2: Medium Risk
☐	TYPE C: Activity generates moderate to high levels of dust, requires greater than 1 work shift for completion	☐	GROUP 3: Medium/High Risk
☐	TYPE D: Major duration and construction activities requiring consecutive work shifts.	☐	GROUP 4: Highest Risk

Classification of Required Preventive Measures

	Construction Activity			
Patient Risk Group	**TYPE A**	**TYPE B**	**TYPE C**	**TYPE D**
LOW Risk Group	I	II	II	III/IV
MEDIUM Risk Group	I	II	III	IV
HIGH Risk Group	I	II	III/IV	IV
HIGHEST Risk Group	II	III/IV	III/IV	IV

Step 3: Required Preventive Measures Classification: _____

a) CLASS I	1. Execute work by methods to minimize raising dust from construction operations. 2. Replace any ceiling tile displaced for inspection immediately when unattended if outside construction barrier. 3. Construction workers should use elevators designated "for staff use."
b) CLASS II	**Follow all precautions for CLASS I, above. Follow these additional precautions:** 1. Obtain signed Risk Assessment from Hospital Epidemiology before work begins. 2. Provide active means to prevent airborne dust from dispersing into air. Complete all critical barriers before construction begins. 3. Remove or isolate HVAC system in areas where work is being performed to prevent contamination of the duct system. Negative or neutral pressure in work site is preferred. 4. Block off and seal air vents. Seal unused doors with duct tape. 5. Water mist work surfaces to control dust while cutting. 6. Contain construction waste before transport in covered containers. 7. Keep dust and accumulated dirt in the work site to a minimum. Use disinfectant to wipe soiled or dusty surfaces. Keep area around the site clean. Wet mop with disinfectant to minimize dust and debris in and around work site. Use HEPA filtered vacuum cleaner when vacuuming. 8. Place dust control mat at entrance and exit of work site; cover sufficient area so both feet contact the mat. Replace or clean when no longer effective. 9. Remove barrier materials carefully to minimize spreading dirt or debris from construction area. Wipe casework and horizontal surfaces at completion of project. 10. Environmental Services performs final cleaning prior to job being turned over to owner.
c) CLASS III	**Follow all precautions for CLASS I and II above. Follow these additional precautions:** 1. Class III projects lasting more than two weeks require solid, not plastic, barriers. 2. Seal holes, pipes, conduits and punctures appropriately. 3. Maintain negative air pressure within the work site and utilize HEPA equipped air filtration units. 4. Cover construction supplies and materials during transport into the facility and work site.
d) CLASS IV	**Follow all precautions for CLASS I, II, and III above.** 1. Class IV projects lasting more than two weeks require solid (not plastic) barriers. 2. Class IV may require additional measures as determined by Hospital Epidemiology and Plant Engineering For example, workers could be vacuumed with HEPA vacuum before leaving the worksite or could wear cloth or paper coveralls (e.g., bunny suits) and/or shoe covers when exiting the project site and traveling through neighboring clinical areas.

Additional Requirements or Concerns:		
Permit Requested By Date:	Facilities Officer Approval Date:	Infection Prevention Approval Date:

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/00**	**SUBJECT:**	**Epidemiologic Investigation of a Suspected Outbreak**
REVISION DATE~~(S)~~:	**03/02, 03/05, 07/11, 08/14, 07/17 06/20**		

Infection Control Department Approval:	**~~04/20~~12/22**
Infection Control Committee Approval:	**~~04/20~~04/23**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/20~~04/23**
Administration Approval:	**~~06/20~~05/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/20**

A. **PURPOSE:**

1. To provide guidelines for uniform and complete investigation of suspected outbreaks of Healthcare Associated Infections (HAI) or community acquired infections seen in the hospital.

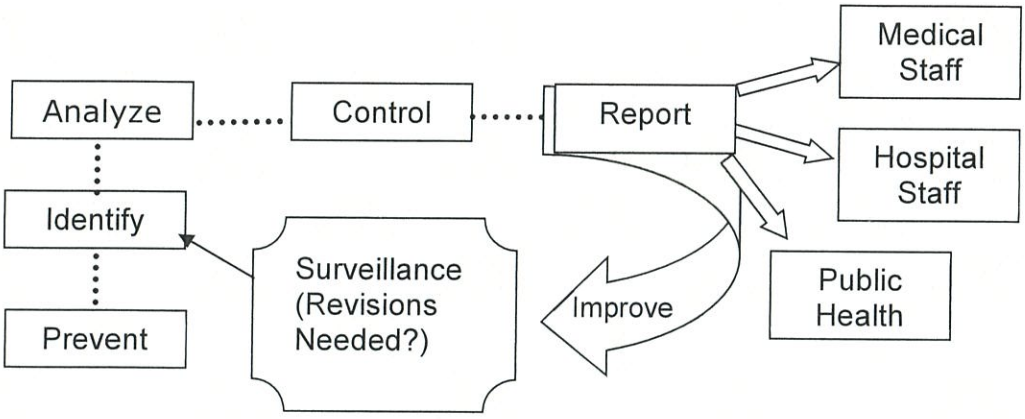
B. **POLICY:**

1. The Infection Control Committee shall have ultimate responsibility for investigating outbreaks and developing policies aimed at prevention and control of Healthcare Associated Infections (HAI). If an outbreak is suspected, the hospital epidemiologist or **their**~~his~~ designee will direct the investigation. The aim of the process is to identify the source of the organism and the mode of spread so that infection control measures can be instituted to halt an outbreak.
2. An outbreak is defined as an increase over the expected occurrence of an event.

C. **PROCEDURE:**

1. The Medical Director of Infection Control along with the Infection Preventionist(s) will determine whether a situation is a probable outbreak that poses a threat to the health of patients, employees or visitors and warrant further investigation. Early identification of a suspected outbreak is important. The Infection Control department will take the following investigative steps:
   a. Confirm that an outbreak exists. Determine of the number of "cases" exceeds the background rate, ie: Any increase in infection incidence found during routine surveillance.
   b. Identify all individuals who meet the case definition (patients and staff) and develop a line listing of cases. (See Data Collection Tool)
   c. Confirm laboratory findings with Lab department.
   d. Ask Lab to collect appropriate clinical specimens and save all outbreak specific isolates from potential cases.
   e. Compare exposure of identified cases to understand the route of transmission and potential risk factors.
   f. Appropriately isolate all individuals who meet the case definition.
   g. Implement immediate control measures as needed.
   h. Report suspected outbreak to local San Diego Public Health (SDPH) Epidemiology department and California Department of Public Health (CDPH) and follow guidance provided.

i. Local & state agencies will assist with case identification, development of investigative approach, prevention and control measures and assist with specimens.
j. Communicate with department heads, microbiology director, administrators, and employee health as appropriate.
k. Implement guidance from local and state agencies.
l. Perform ongoing surveillance for any continued signs of the outbreak.
m. Evaluate efficacy of control measures implemented.
n. When the control measures have terminated transmission, declare outbreak is over.
o. Change policies and procedures if necessary.
p. Report findings to Infection Control Committee and other Committees as needed.



D. **RELATED DOCUMENT(S):**
1. Data Collection Tool - Sample

E. **REFERENCE(S):**
1. Campbell, E. (2014). Chapter 12 Outbreak Investigation. APIC Text of Infection Control and Epidemiology. Washington DC: APIC, 4th Edition.
2. CDC Principles of Epidemiology: Lesson 6 Investigating an Outbreak
3. CDC: Outbreak Investigations in Healthcare Settings https://www.cdc.gov/hai/outbreaks/ **(Reviewed 11/22)**
4. CDPH: Outbreaks and Unusual Infection Occurrences 2017

Data Collection Tool - Sample

MR #	Patient's Name	Admit Date	Date of Onset of S & S	Culture Date	Culture Results	Invasive Device or Procedure	Device / Procedure Date	Unit	Comments

Tri-City Healthc~~Care~~ District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 07/03 SUBJECT: Hand Hygiene

REVISION DATE: 04/08, 07/11, 12/14, 07/17, 06/20

Infection Control Department Approval:	~~04/20~~11/20
Infection Control Committee Approval:	04/2004/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~04/23
Administration Approval:	~~06/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. PURPOSE:

1. The purpose of hand hygiene is to remove microorganisms and reduce the risk of transmitting disease and/or significant pathogens to patients, healthcare workers, environment, and visitors.

B. GENERAL INFORMATION:

1. Hand hygiene is the single most important activity for preventing transmission of infectious microorganisms.
2. Multiple studies have shown that the hands of healthcare workers carry large numbers of germs. Transient flora are acquired from patients or contaminated environmental surfaces and are more likely to cause healthcare-associated infections than resident flora – bacteria always found on the skin. Normal shedding of skin cells spreads germs that are carried on the skin.

C. POLICY STATEMENTS:

1. Length of nails/Fingernail polish/ Artificial nails:
   a. Fingernails must be less than ¼ inch in length, clean and trimmed. Long natural nails carry twice the number of germs compared to short (less than ¼ inch) natural fingernails.
   b. Fingernail polish is permitted as long as there is no chipping or peeling. Freshly applied nail polish does not increase the number of bacteria but chipped nail polish may support the growth of larger numbers of organisms on fingernails.
   c. Pursuant to Center for Disease Control (CDC) guidelines and the World Health Organization (WHO), all health care workers and providers who provide direct "hands on" patient care cannot wear artificial fingernails, nail extenders/tips or nail jewelry.
2. Wearing gloves does not provide complete protection against microorganisms. Up to 30% of healthcare workers who wear gloves during patient contact will be carrying germs from the patient they just touched after the gloves are removed. Bacteria and viruses gain access to their hands through small holes in gloves and/or during glove removal.
3. Indications for hand washing and hand antisepsis:
   a. Wash hands with hospital-approved soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material (all body fluids except sweat).
   b. If hands are not visibly soiled, may use an alcohol-based waterless antiseptic agent.
   c. Perform hand hygiene before and after patient contact.
   d. Perform hand hygiene after contact with a patient's surroundings/ environment.
   e. Perform hand hygiene after contact with body fluids or excretions, mucous membranes, intact and non-intact skin, or wound dressings.
   f. Perform hand hygiene before performing an aseptic task.
   g. Perform hand hygiene before accessing and inserting invasive devices.

h. Perform hand hygiene before preparing and administering medication.
i. Perform hand hygiene before donning gloves and after removing gloves.

D. **HAND HYGIENE TECHNIQUES:**

1. Waterless Based Products:
   a. When decontaminating hands with a waterless alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
   b. If an adequate volume of an alcohol-based hand rub is used, it should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use.
2. Soap and Water:
   a. When washing hands with soap, wet hands first with warm water, apply 3 to 5 ml of detergent to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet.
3. Gloves:
   a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur.
   b. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients.
   c. Change gloves during patient care if moving from a contaminated body site to a clean body site.
   d. Perform hand hygiene after glove removal.
4. Surgical Hand Antisepsis
   a. See Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis for details.

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

1. Administrative - Human Resources Policy: 8601-415 Dress and Appearance Philosophy Policy
2. Patient Care Services Policy: Surgical Services: Surgical Attire Policy
3. Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis

F. **REFERENCE(S):**

1. Center for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee: HICPAC/SHEA/APIC/IDSA MMWR 2002; Vol.51
2. WHO Guidelines on Hand Hygiene in Health Care 2009
3. https://www.cdc.gov/handhygiene/providers/index.html

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

INFECTION CONTROL

ISSUE DATE:	**09/01**	**SUBJECT:**	**Management of Patients with HIV-Infection/AIDS**
REVISION DATE:	**09/04, 10/13, 07/17, 06/20**		

Infection Control Department Approval:	**~~04/20~~01/23**
Infection Control Committee Approval:	**~~04/20~~04/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/20~~04/23**
Administration Approval:	**~~06/20~~05/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/20**

A. **GENERAL INFORMATION:**

1. Acquired Immunodeficiency Syndrome (AIDS) is caused by a retrovirus, called Human Immune Deficiency Virus (HIV). Routine social or community contact with an HIV-infected person carries no risk of transmission. HIV is only contacted by sexual exposure and exposure to blood or tissues. For example:
   a. Unprotected sexual intercourse.
   b. Direct contact of your blood with an infected person's blood.
   c. Sharing of HIV contaminated needles and syringes.
   d. From mother to newborn, either during pregnancy or after birth.
   e. Breastfeeding by HIV-infected mothers.

B. **PROCEDURE:**

1. The isolation of the individuals for HIV-infection is unnecessary, ineffective and unjustified.
2. Standard precautions apply to all hospitalized patients and additional precautions (Airborne, Droplet, or Contact) may be appropriate for specific infections.
3. Place all HIV positive patients with pulmonary infiltrates in Airborne Precautions until three sputum smears are Acid-Fast Bacilli (AFB) negative or until a diagnosis other than tuberculosis is clearly established.
4. If HIV testing is ordered, follow the policy as outlined in Lab Administrative: Authorization for Laboratory Testing.
5. Healthcare workers with exposure to blood or other body fluids are to follow the Patient Care Services: HIV Testing in an Occupational Exposure Policy.

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

1. Employee Health: HIV Guideline Grid
2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Policy
3. Infection Control: Bloodborne Pathogen Exposure Control Plan Policy
4. Patient Care Services: HIV Testing In an Occupational Exposure Policy

D. **REFERENCES(S):**

1. California Healthcare Association. (2017) Consent Manual. California Healthcare Association, Sacramento, Ca.
2. Center for Disease Prevention and Control. (2001). June 29, 2001 / 50(RR11);1-42 Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV **Reviewed 11/22.**
3. https://www.cdc.gov/hai/organisms/hiv/hiv.html

4. Recommendations for the prevention of HIV transmission in health-care settings. MMWR, 36, 1S -18S. **Reviewed 11/22.**
5. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. Published: ~~-~~9/25/2013 https://stacks.cdc.gov/view/cdc/20711

Tri-City Healthc~~-Care~~ District
Oceanside, California

INFECTION CONTROL ~~MANUAL~~

ISSUE DATE:	**01/85**	**SUBJECT: Meningococcal Exposure**
REVIEW DATE:	**09/03, 10/04, 09/07, 08/14, 03/17, 02/20**	**~~STANDARD NUMBER: IC. 6.2~~**
~~REVISED:~~		

Infection Control Department Approval:	**~~01/20~~12/22**
Infection Control Committee Approval:	**~~01/20~~04/23**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/20~~04/23**
Administration Approval:	**~~02/20~~05/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/20**

A. **PURPOSE**:

1. To help prevent the transmission of disease to and colonization of healthcare workers (HCWs).
2. Health care workers may require prophylactic antibiotics after a significant exposure to a patient with an infection (meningitis, bacteremia, or pneumonia) due to *Neisseria* meningitidis Bacterial meningitis infection presents as a sudden onset of fever, headache, and stiff neck. The symptoms of bacterial meningitis can appear quickly or over several days. Typically they develop within 3 – 7 days after exposure.
3. Prophylaxis is most effective within the first 4 days post-exposure.
4. Patient is placed in Droplet Precautions if disease is known or suspected before lab confirmation.
5. Chemoprophylaxis is offered to HCWs if:
   a. the patient's CSF gram stain is positive *for* gram negative diplococci, or blood, sputum, or CSF is culture positive for Neisseria meningitis and
   b. (2) HCW had an "intimate exposure" as defined on the Meningococcal Meningitis worksheet (Appendix A), was not wearing appropriate PPE, and the patient was not receiving appropriate antibiotics for at least 24 hours.
   c. Staff Roles (See hyperlink for flow chart):
   d. Microbiology: report significant stains and cultures to patient's attending physician, public health and Infection Preventionist (M – F 8am to 5pm) or the Administrative Supervisor after hours and weekends.
   e. Infection Preventionist or Administrative Supervisor: assist in identification of departments or units involved and report to San Diego County Health and Human Services Epidemiology department: # (619) 692-8499FAX # (858) 715-6458
   f. Charge Nurse: review the patient's chart to identify exposed staff. Complete and send attached Meningococcal Meningitis Worksheet (Appendix A) to Employee Health.
   g. ED Base Coordinator to 1) fill out Communicable Disease Exposure Report Form (from County of San Diego Public Health Department: Division of Emergency Medical Services 2) send form to Infection Control staff for follow up 3) notify the EMS agency's Infection Control Officer of exposure.
6. Exposed employee: complete an Injury/Illness Investigation Report and sign in to be seen in Emergency Department.

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

1. Meningococcal Meningitis Worksheet
2. Neisseria Meningitis Exposure Flowchart

C. **REFERENCE(S):**

1. APIC, Ready Reference to Microbes, Washington DC: 3rd Edition. Brooks, K, 2012
2. APIC, APIC Text of Infection Control and Epidemiology, Washington, DC: 4th Edition. Association for Professionals in Infection Control and Epidemiology, 2014.
3. Gilmore A, Stuart J, Andrews N, Risk of secondary meningococcal disease in health-care workers. Lancet 2000, 11;356(9242): 1654-1655.
4. http://www.cdc.gov/meningitis/bacterial.html
5. **Centers for Disease Control and Prevention. Occupational transmission of Neisseria meningitidis — California, 2009. MMWR Morb Mortal Wkly Rep. 2010;59(45):1480-1483. ()Reviewed 11/22**

~~4.~~

Tri-City Health Care District
Oceanside, California

Meningococcal Meningitis Worksheet

Charge Person/Department Manager: _____

Date:_____ Time:_____ Patient's MR#_____

Staff Involved:	Exposed	
1.	Y	N
2.	Y	N
3.	Y	N
4.	Y	N
5.	Y	N
6.	Y	N
7.	Y	N
8.	Y	N
9.	Y	N
10.	Y	N
11.	Y	N
12.	Y	N
13.	Y	N
14.	Y	N
15.	Y	N

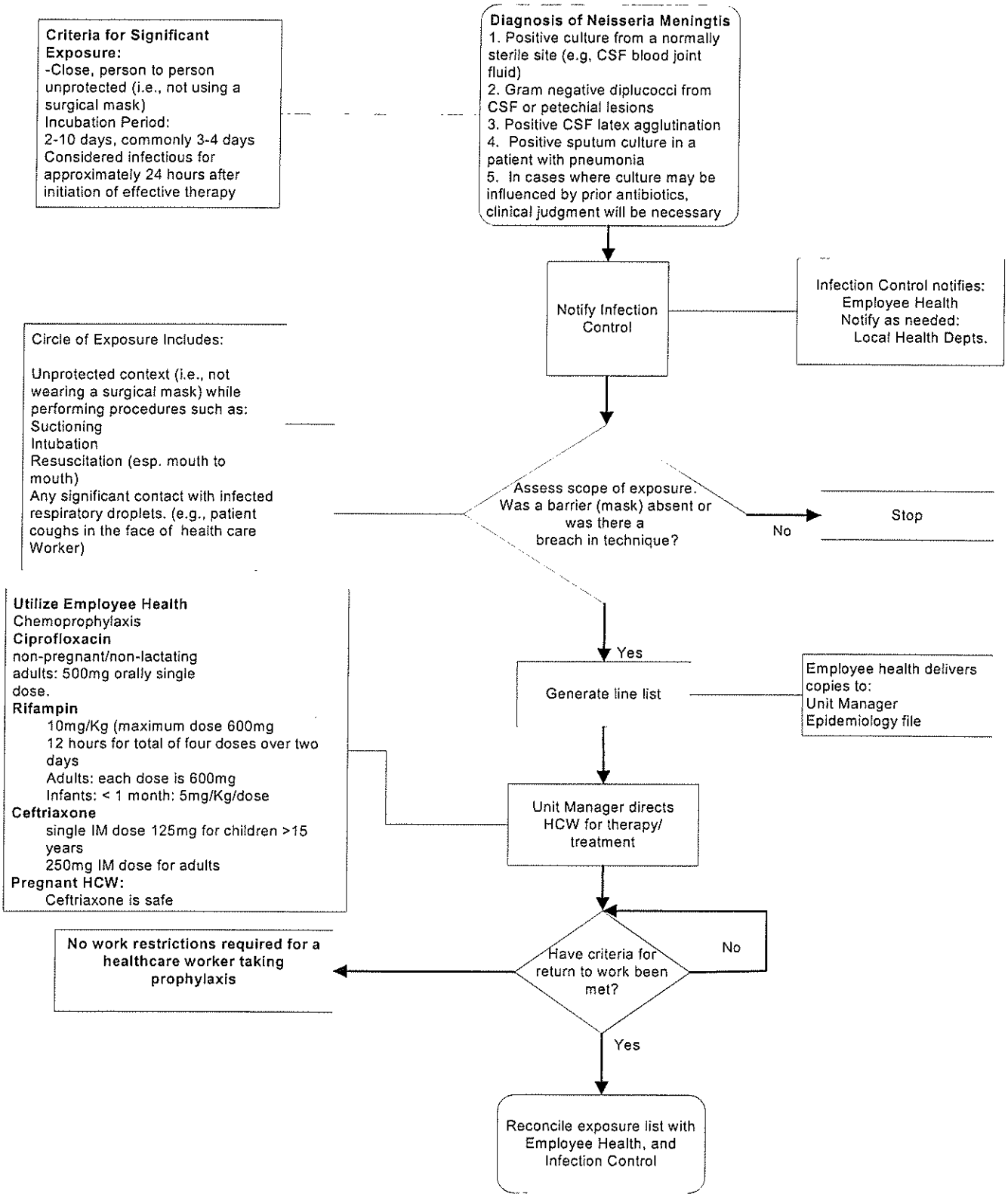
Exposure is defined as intimate and unprotected (no mask or face shield) contact with a patient with meningococcal disease (*Neisseria meningitis*) prior to antibiotic administration for at least 24 hours. There is a negligible risk of disease following casual contact. The following are examples of an "exposure"

Mouth to mouth resuscitation
Suctioning without using personal protective equipment (mask and goggles or face shield)
Participation in intubation without using personal protective equipment (mask and goggles or face shield)
Oral or endoscopic examination without using personal protective equipment (mask and goggles or face shield)
Assisting with vomiting patient without using personal protective equipment (mask and goggles or face shield)
Other mucus-membrane contact with respiratory secretions.

All staff identified as "exposed" are directed to the Emergency Department for further evaluation and possible prophylactic treatment.

Please fax the completed form to Employee Health Services at (760) 940-4005.

Healthcare Worker Exposure to Neisseria Meningitis
This algorithm does not need to be done on every case of exposure to Meningitis only for exposure to Neisseria Meningitis



Tri-City Healthc~~-~~are District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 01/92 **SUBJECT: Scabies and Lice**

REVISION DATE~~(S)~~: 09/04, 10/13, 08/16, 08/19

Infection Control Department Approval:	~~06/19~~12/22
Infection Control Committee Approval:	~~07/19~~04/23
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~07/19~~04/23
Administration Approval:	~~08/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

A. **PURPOSE:**
1. Provide assistance in the management and identification of scabies and lice. To prevent transmission in the event of occupational exposure to scabies and or lice.

B. **INTRODUCTION:**
1. **Scabies** is a parasitic infestation of the skin caused by the human itch mite, *Sarcoptes scabiei.* The microscopic scabies mite burrows into the upper layer of skin where it lives and lays eggs. The typical presenting symptom in most patients with scabies is intense itching (pruritus), which is usually more severe at night, and a pimple like (papular) rash. In the immune-compromised, elderly, disabled, homeless or debilitated patients a generalized dermatitis more widely distributed is seen with extensive scaling, vesiculation and crusting. "Norwegian" (Atypical scabies) or crusted scabies presents as a crusty, scaly dermatitis usually of the hands and feet. Persons with crusted scabies have thick crusts of skin that contain large number of scabies mites and eggs. Itching is remarkably minimal.
2. **Lice** are parasitic insects that can be found on people's heads and bodies including the pubic area which can result in severe itching. Lice are host specific and those of animals do not infest humans. Human lice survive by feeding on human blood. Lice move by crawling; they cannot hop or fly. Three types of lice are:
   a. Head lice are 2.1-3.3mm in length. Head lice infest the head and neck and attach their eggs to the base of the hair shaft.
   b. Body lice are 2.3-3.6mm in length. They are rarely found on the body except when feeding, they are usually found on clothing. They are known to spread disease.
   c. Pubic (crab) lice are 1.1-1.8mm in length. Pubic lice are typically found attached to hair in the pubic area but sometimes are found on coarse hair elsewhere on the body (ie: eyebrows, eyelashes, beard, mustache, chest and armpits, etc.)

C. **TRANSMISSION:**
1. **Scabies**:
   a. The scabies mite usually is spread by direct prolonged skin to skin contact with a person who has scabies. Scabies can be indirectly spread by sharing articles of clothing, towels or bedding with an infected person. On a person, scabies mites can live for as long as 1-2 months. Scabies mites generally do not survive more than 2-3 days away from human skin.
   b. Persons with "Norwegian" or crusted scabies are highly contagious to other persons due to the large number of mites present in the exfoliating scales. Infestation can spread easily by brief direct skin to skin contact and by contamination of items such as clothing, bedding or furniture.

2. **Lice:**
   a. Transmission requires direct contact with an infected person & objects used by them (ie: shared clothing and head wear) Lice crawl, but do not hop or fly. Eggs hatch within 7-10 days. Time of survival off host: Head lice: 2 days, Body lice: 4-7 days and Pubic (crab) lice 1 day.

D. **POLICY:**
1. Place patient in Contact Precautions upon realizing or suspecting the patient has scabies or lice.
2. Examination of the patient by nursing and medical staff to determine if scabies or lice are present.
   a. Bag up all personal clothing and belongings and seal the bag tightly. Send clothes and personal belongings with family if possible.
3. Provide topical treatment as prescribed per physician orders.
4. Continue Contact Precautions until 24 hours after **effective** treatment.
5. Bedding and hospital gown should be changed every 24 hours post topical treatment.
6. After patient is discharged and insects are visible in the room, place a work order for Building Engineering to contact Pest Control to inspect room.
7. Once room is cleared by inspection, have Environmental Services terminally clean room.

E. **OCCUPATIONAL EXPOSURE:**
1. Standard and Contact precautions should prevent the transmission of most cases of scabies and lice. If an exposure to a patient with scabies and or lice occur before Contact Precautions are applied and the patient is treated the employee should:
   a. Immediately report the exposure to their Supervisor, Charge Nurse or Manager as per Employee Health & Wellness policy: Guidelines for Reporting Exposure.
2. Employee Health Services will institute appropriate follow up as needed.

F. **RELATED DOCUMENT(S):**
1. Employee Health and Wellness Policy Manual: Injury & Illness Prevention Program
2. Employee Health and Wellness Policy Manual: Guidelines for Reporting Exposures policy
3. Infection Control Policy: Bloodborne Exposure Control Plan
4. Infection Control Policy: Philosophy
5. Infection Control Policy: Standard and Transmission Based Precautions
6. Infection Control Policy: Tuberculosis Exposure Control Plan

G. **REFERENCE(S):**
1. APIC Text of Infection Control and Epidemiology, 4th edition, 2014
2. Control of Communicable Diseases Manual, D.L. Heymann, MD, Ed. 19th edition 2008
3. http://www.cdc.gov/parasites/scabies/index.html (Accessed 11/23/22)
4. http://www.cdc.gov/parasites/lice/ (Accessed 11/23/22)

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/01 **SUBJECT:** Waterborne Illness

REVISION DATE: 09/04, 10/07, 10/10, 10/13, 01/17, 12/19

Infection Control Department Approval:	~~10/19~~12/22
Infection Control Committee Approval:	~~11/22~~04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/19~~04/23
Administration Approval:	~~11/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **INTRODUCTION:**

1. Legionellosis is a collective term describing infection produced by the pathogen Legionella, a bacterium found in water environments. Most hospital hot water systems are colonized with Legionella, which is introduced into institutional water distribution systems from public/municipal water systems (that do not routinely screen water for the presence of Legionella). Since Legionella is chlorine tolerant, it will survive many of the standard municipal water treatment protocols. The transmission of Legionella in healthcare facilities is by the inhalation of aerosolized water contaminated with Legionella bacteria.

B. **PURPOSE:**

1. This plan describes how the organization will establish and maintain a utility systems management program to reduce the potential for organizational-acquired illness related to waterborne illness. The plan provides processes to decrease the risk of transmission through contaminated patient care equipment. Steps for investigation of outbreaks and remediation are outlined if potential nosocomial infections were identified.

C. **SCOPE:**

1. This plan applies to all aerosolizing water systems in Tri-City Medical Center (for example: cooling towers, domestic hot water taps, evaporative coolers, and etc.) and to all immunocompromised patients admitted to the hospital.
2. Program Administration
   a. The Manager of Safety/Environment of Care is responsible for the implementation, maintenance and administration of the Environmental Health & Safety Committee.
   b. To assist the Manager of Safety/Environment of Care in carrying out their duties the Environmental Health & Safety Committee, Engineering Department, Infection Control Department, and Microbiology Department will be contacted as needed.
   c. Engineering is responsible for the following (See Appendix A)
      i. Perform an initial assessment of the environmental risk from the plumbing system. Identify factors with potential to amplify growth of waterborne microorganisms such as the domestic hot water heater, dead legs of low flow conditions, water temperature, and maintenance.
      ii. Perform an initial assessment of the environmental risk from the heating, cooling and humidifying system that produces aerosolized water or involves standing water.
      iii. Develop and document maintenance schedules to decrease risk (i.e. blow down hot water tanks, cleaning cooling towers and use of an effective biocide).

d. Infection Control Department is responsible for the assessment of the clinical risk of the organization's patient population including the following: (See Appendix B)
   i. Identify the treatment/care areas for patients at greatest risk of contracting Legionellosis.
e. Ongoing surveillance for facility acquired Legionellosis.
   i. Microbiology Laboratory: Preprinted order for bronchoscopy specimen includes screening for Legionella.
   ii. Laboratory methods used at Tri-City Medical Center for diagnosis of legionella infection include the following

3. Urinary antigen is relatively inexpensive, simple, and rapid.
4. Legionella cultures
   a. If the culture grows positive for Legionella, our Laboratory will perform serotyping for Legionella species. If it is not serogroup 1, the Laboratory will final the report out as Legionella species, not Legionella pneumophila serogroup 1.

D. **RISK ASSESSMENT:**

1. See Environmental Risk Assessment for a table outlining the environmental assessment.
2. See Infection Control Risk Assessment for a table outlining the clinical risk of TCMC's patient population
3. See Legionella Fact Sheet.

E. **PRIMARY PREVENTION:**

1. Develop a management plan as a result of the assessment that includes standard operating procedures (SOP's) for maintenance and operation of water systems
   a. Develop a system to document and log findings as a result of these SOP's such as temperatures, blow down of hot water tanks, cooling tower inspections etc.
   b. Maintenance and audit program for any systems that are currently installed to limit Legionella amplification in aerosolizing systems such as cooling towers and /or potable water treatment systems (e.g. copper silver or chlorine dioxide).
   c. Inspect cooling towers/evaporative coolers to ensure that they are in proper condition and operate as designed. Install drift eliminators if needed.
   d. Use an oxidizing biocide continuously to prevent the formation of biofilms and control biological growth. (E.g. bromine, chlorine, iodine, chlorine dioxide, ozone, etc.) And intermittently a non-oxidizing biocide (e.g. DBNPA, isothiazoline, etc.).
   e. Maintain towers according to manufacturer's recommendations or alternative equipment maintenance program. If the tower/cooler is subject to extended shutdown, equipment should be cleaned and treated prior to shut down and again before starting up.
2. Incorporate Infection Prevention strategies in the facilities patient care policies.
   a. Use sterile water or rinsing nebulization devices and other semi-critical respiratory-care equipment after such items have been cleaned and /or disinfected.
   b. Use sterile water to fill reservoirs of devices used for nebulization.
   c. Use sterile water to flush nasogastric tubes.
   d. Protecting patient-care devices and instruments from inadvertent tap water contamination during room cleaning
3. Remediation (if an outbreak of Legionellosis is suspected or identified)
4. Outbreak is defined as at least one case of laboratory-confirmed case of legionellosis that occur in patients who have been hospitalized continuously for >10 days before the onset of illness and/or a possible case (i.e., laboratory-confirmed infections that occur 2 - 9 days after hospital admission.
5. A multidisciplinary team, comprised of members of the Infection Control and Environmental Health & Safety Committees will be utilized to organize the facilities response. A report will be made to the appropriate public health agencies.

Epidemiologic Investigation	Environmental Investigation
Review medical and microbiologic records.	Risk factors among potential environmental exposures (e.g., showers, cooling towers, respiratory-therapy equipment, etc.)
Initiate active surveillance to identify all recent or ongoing cases	Collect water samples from environmental sources implicated by epidemiologic investigation
Develop a line listing of cases by time, place, and person.	Other aerosolized water sources
Determine the type of epidemiologic investigation needed for assessing risk factors. Case-control study - Cohort study	
Gather and analyze epidemiologic information Subtype strains of Legionella spp. cultured from patients & environmental sources Review autopsy records and include autopsy specimens in diagnostic testing	

Control Measures: if water is contaminated with Legionella spp.	Remediation of potable water: in response to identified nosocomial cases
Restrict patients from taking showers and provide clean water for sponge baths	Superheating of water (at least 149degreesF)
Provide sterile water for drinking, tooth brushing, or for flushing nasogastric tubes.	"Shock" hyperchlorination >10 mg/L of chlorine in water
Remove showerheads and faucet aerators monthly for cleaning.	
Use a 1:100 solution of chlorine bleach to disinfect showerheads and aerators.	
Cooling towers should be designed and constructed so that tower drift is directed away from the hospital's air intake system and the volume or aerosol drift is minimized.	

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

1. Engineering Infection Control: Managing Biological Agents to Prevent Waterborne Illness
2. Infection Control Policy: Surveillance Program
3. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
4. Environmental Risk Assessment
5. Infection Control Risk Assessment
6. Legionella Fact Sheet

G. **REFERENCE(S):**

1. CDC - Guideline for Preventing Health Care Associated Pneumonia, 2003http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm (accessed 12/15/2022)
2. CDC - Guideline for Environmental Infection Control in Health-Care Facilities HICPAC 2003 Updated: July 2019 https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines-P.pdf
3. ASHRAE 188: Legionellosis: Risk Management for Building Water Systems http://www.cdc.gov/legionella/health-depts/ashrae-faqs.html (accessed 12/15/2022)
4. CDC: Legionnaires' Disease http://www.cdc.gov/legionella/downloads/fs-legionnaires.pdf
5. Joint Commission Environment of Care Standard (EC.02.05.01) Updated 9.20.17

6. OSHA: Occupational Safety & Health Administration: Legionellosis (Legionnaires' Disease & Pontiac Fever) https://www.osha.gov/SLTC/legionnairesdisease/index.html (accessed 12/15/2022)

Environmental Risk Assessment

1) Municipal water is treated with chloramine. Data suggests that use of monochloramine is effective in eradicating Legionella. Monochloramines can reach distal points in a water system and can penetrate into bacterial biofilms more effectively than free chlorine.

EQUIPMENT	Location	Scale, Rust, or Biofilm Growth	Water Temp.	COMMENTS
Domestic Cold Water	Oceanside Main @ Thunder Dr. 10"	None	Ambient	Oceanside receives water from Municipal Water District of Southern California, all water treated with Chloramine Disinfectant @ 2.5 to 3.0 mg / l level. All backflow regulators are inspected and tested annually.
	Oceanside Main @ Vista Way, 10"	None	Ambient	Same as above.
	Vista Irrigation Main @ Thunder Dr., 8"	None	Ambient	Same as above.
	Hospital piping system.	None	Ambient	Entire domestic cold water system is run in copper and brass piping to prevent scale, rust or bio-film.
	(2) 10,000 gallon refill tanks on Pavilion roof top.	None, tanks are rubber lined.	Ambient	Tanks are routinely opened and inspected. Tanks are not used for storage but replenished constantly. Water is supplied up to tanks and then pressure and gravity feed down to building.
Domestic Hot Water	Steam fed Heat Exchangers (6) throughout hospital	None	Monitored by computer to supply Title 22 required temperature water, 105 to 120 degrees F.	Domestic hot water piping is all run in copper and brass to prevent scale, rust or bio-film. All hot water systems are circulated constantly in order to provide constant temperature at sinks.
Reverse Osmosis and De-Ionized Water	Throughout facility, main system in penthouse of center tower, booster tanks located at Lab and 2 Pavilion.	None	Ambient	This system is highly filtered and treated water (Ultra Violet). System main function is for Sterile Processing and Lab Equipment and is routinely tested and monitored by our in-house laboratory
Irrigation Water	Grounds	None	Ambient	Irrigation water is supplied from Vista Irrigation District (VID) who obtains their water from MWD, same as above.
Heating Hot Water	Throughout Facility, used for heating only, does not come in contact with patients.	None	Varies depending on outside air temperature, usually 140 degrees F. in winter, 120 degrees F. in summer.	Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system.

EQUIPMENT	Location	Scale, Rust, or Biofilm Growth	Water Temp.	COMMENTS
Chilled Water	Throughout Facility, used for cooling (air conditioning), does not come in contact with patients.	None	Varies depending on outside air temperature and demands of building, usually ranges between 42 to 55 degrees F.	Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system.
Condenser Water Loop	Isolated to the Central Plant only. Cooling Tower is part of Air Conditioning System. Located 300 ft. away from main building.	Minor Bio-film, potential for rust and scale.	Temperature ranges between 78 to 95 degrees F. depending on outside air temperature and load on the system.	Requires most attention to ensure bio-film is kept to a minimum. Water is treated with sulfuric acid, bleach and biocides. A carefully designed and monitored program has been developed by a consultant. Water is tested by facilities staff to ensure we are within parameters.
Thermal Ice Storage Loop	Isolated to Central Plant only. Part of Air Conditioning system.	None	Temperature range is from 18 to 40 degrees F.	Glycol and water mix to specific gravity mix, closed loop system.
Steam Loop	Throughout, used for sterilization of instruments, heating hot water & domestic hot water through heat exchangers & humidification.	None	Average Temperature is 300 degrees F.	Basically a closed loop system except for discharge at sterilizers and humidifiers. Due to high temperature, not an issue.

Infection Control Risk Assessment

1) No cases of nosocomial Legionellosis have been identified at Tri-City Medical Center within the past ten years.
2) Legionnaires cultures are performed on bronchoscopy cultures and urinary Legionella antigen test is available in house.

High-Risk Patients	Unit	Prevention Strategies
Chemotherapy and Oncology	TELEMETRY	Showers 1) The degree to which contaminated water is aerosolized into respirable droplets; 2) The proximity of the infectious aerosol to the potential host
COPD	Pulmonary Services	Sterile water used in nebulizers
End-stage renal disease	Dialysis	Filters are used in water lines in dialysis units, for the purpose of providing bacteria-free water for instrument reprocessing. Additionally, a reverse osmosis (RO) unit is usually added to the distribution system leading to PE areas.
Endoscopy	Surgery Services	Filters are used in water lines for the bronchoscope and endoscope washer/disinfectors.
Others	ICU, TELEMETRY, Med/Surg, Surgery, Pediatrics, Maternal/Child Services, NICU and ED	• Naso-gastric tubes are flushed with sterile water. • Reusable respiratory treatment devices that aerosolize fluids are rinsed with sterile water after use.

Tri-City Health Care District

Legionellae Fact Sheet

Infection and Disease

Legionellae are bacteria. When Legionellae are present in aquatic environments, the risk of catching an infection depends on several factors: conditions favorable for growth of the organism, a way of releasing the bacteria (e.g., aerosolization of colonized water), the organism reaches a site where it is capable of causing infection, which specific strains of bacteria are involved, and the susceptibility of the host. Over 40 species of *Legionella* have been identified; *L. pneumophlla* appears to be the easiest to catch and causes approximately 90% of cases of Legionellosis. Older persons and those who smoke tobacco or have chronic lung disease are more likely to become infected. Persons whose immune system is decreased (certain drugs or underlying medical conditions) are at particularly high risk.

Habitats

Legionellae bacteria are commonly present in natural and man-made water environments. The organism is occasionally found in other sources, such as mud from streams and potting soils. In natural water sources and municipal water systems, Legionellae are generally present in very low or undetectable concentrations. However, under certain circumstances within manmade water systems, the concentration of organisms may increase markedly, a process termed "amplification." Conditions that are favorable for this amplification include water temperatures of 25-42^{0}C (77-108^{0}F), stagnation, scale and sediment, biofilms, and the presence of amoebae.

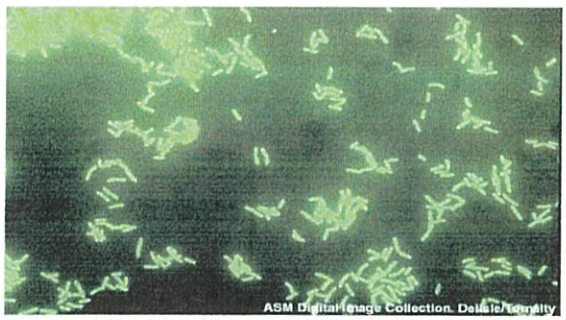
Legionellae infect and multiply within several species of free-living amoebae, as well as ciliated protozoa. The initial site of infection in humans with Legionnaires' disease is the pulmonary macrophage. These cells engulf Legionellae and provide an environment that is remarkably similar to water protozoa. Within these cells the bacteria can grow and multiply. Hence, Legionellae may be considered protozonotic; i.e., they naturally infect free-living amoebae and incidentally infect the phagocytic cells within human lungs under certain circumstances.

There is an indication that certain materials influence growth of Legionella. Natural rubbers, wood, and some plastics have been shown to support the amplification of *Legionella,* while other materials such as copper inhibit their growth. Generally, *Legionella* thrive in diverse, complex microbial communities because they require nutrients and protection from the environment. Controlling the populations of protozoa and other microorganisms may be the best means of minimizing *Legionella.*[2]

Transmission of Legionnaires' Disease

Investigations of outbreaks of Legionnaires' disease supply most of the information we have about how the disease is passed to humans. These studies suggest that, in most instances, transmission to humans occurs when water containing the organism is aerosolized in respirable droplets (1-5 micrometers in diameter) and inhaled by a susceptible host. A variety of aerosol-producing devices have been associated with outbreaks of Legionnaires' disease, including cooling towers, evaporative condensers, showers, whirlpool spas, humidifiers, decorative fountains, and a grocery store produce mister. Aspiration of colonized drinking water into the lungs has been suggested as the mode of transmission in some cases of hospital-acquired Legionnaires' disease.

The most effective control for most diseases, including Legionellosis, is prevention of transmission at as many points as possible in the disease's chain of transmission. If one preventive measure fails, others will be in place and act as fail-safe mechanisms. With this philosophy in mind, it may be desirable to design measures to prevent transmission of Legionellosis at as many points as possible in the disease's chain of transmission. The Waterborne Illness policy outlines the preventative steps Tri-City Medical Center has taken to break this chain of transmission.



Tri-City Medical Center
Oceanside, California

INFECTION CONTROL ~~MANUAL~~

ISSUE DATE: 01/17 SUBJECT: Zika Virus

REVISION DATE~~(S)~~: 02/20

Infection Control Department Approval:	~~11/19~~12/22
Infection Control Committee Approval:	~~01/20~~04/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/20~~04/23
Administration Approval:	~~02/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. DEFINITION:
1. Zika virus is a member of the virus family Flaviviridae and the genus Flavivirus. It is spread by daytime-active Aedes mosquitoes, such as A. aegypti and A. albopictus. Its name comes from the Zika Forest of Uganda, where the virus was first isolated in 1947. Zika virus is related to the dengue, yellow fever, Japanese encephalitis, and West Nile viruses. Since the 1950s, it has been known to occur within a narrow equatorial belt from Africa to Asia. From 2007 to 2016, the virus spread eastward, across the Pacific Ocean to the Americas and the Caribbean leading to the 2015–16 Zika virus epidemic.

B. TRANSMISSION:
1. Zika virus is primarily transmitted to humans through the bite of an infected Aedes species mosquito (Ae. aegypti and Ae. albopictus). In addition, Zika virus can be transmitted from a pregnant womaen to her fetus, and through sex. It is very likely that Zika can be transmitted through blood transfusion. The Zika virus remains in a person's blood an average of 7 days after being infected. Zika virus is not transmitted through the air or directly from one person to another through casual contact.

C. SYMPTOMS:
1. Many people infected with Zika virus won't have symptoms or will only have mild symptoms. People usually don't get sick enough to go to the hospital, and they very rarely die of Zika. Symptoms of Zika are similar to other illnesses spread through mosquito bites, like dengue, yellow fever, chikungunya, and West Nile. There is an association between Zika and Guillain-Barre syndrome, a disease affecting the nervous system.
   a. The most common symptoms are: fever, rash, joint pain, conjunctivitis (red eyes). Others include muscle pain & headache. Symptoms can last for several days to a week.
   b. Zika during pregnancy can cause birth defects of the fetal brain called microcephaly (small head and brain) and other brain defects. Other problems have been detected among fetuses and infants infected with Zika virus before birth, such as defects of the eye, hearing defects, impaired growth and developmental delays.

D. PRECAUTIONS:
1. All healthcare personnel when providing any care to a suspected or confirmed Zika patient should follow Standard Precautions per Infection Control (IC) Policies: Standard and Transmission Based Precautions and Bloodborne Pathogens Exposure Control Plan.
   a. Standard precautions include, but are not limited to:
      i. Hand hygiene
      ii. Gloves

iii. Gown
iv. Mask and eye protection to avoid direct contact with blood and other potentially infectious material, including laboratory specimens.

E. **DIAGNOSIS & TESTING:**

1. Diagnosis of Zika is based on a person's recent travel history, symptoms, and test results. Testing will be performed based on Centers for Disease Control and Prevention (CDC) current recommendations.
2. Healthcare providers wishing to have a patient tested for Zika virus MUST contact the local San Diego County Public Health Epidemiology department for consultation and approval at (619)-692-8499.
   a. For after hours, weekends or holidays call 858-565-5255 and ask for the Epidemiology Duty Officer.
3. The healthcare provider will be directed by the Epidemiologist to fill out a CDPH-Viral and Rickettsial Disease Lab Specimen Submittal form which is required when testing is requested:
   a. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/VRDL_Specimen_Submittal_Forms.aspx (accessed ~~11-19-19~~**12/19/22**)
4. The healthcare provider must submit a copy of this form to the Laboratory in order for a specimen to be ordered and processed. Contact the Laboratory to obtain specimen at ext 7906 or 7907.
5. Staff should contact Infection Prevention & Control at extension 5696 with any suspect cases.

F. **OCCUPATIONAL EXPOSURE:**

1. Immediately report the exposure to staff Supervisor, Charge Nurse or Manager as per Employee Health & Wellness policy: Guidelines for Reporting Exposure.
2. Employee Health Services will institute appropriate follow up.

G. **FORM(S):**

1. General Purpose Specimen Submittal Form Sample

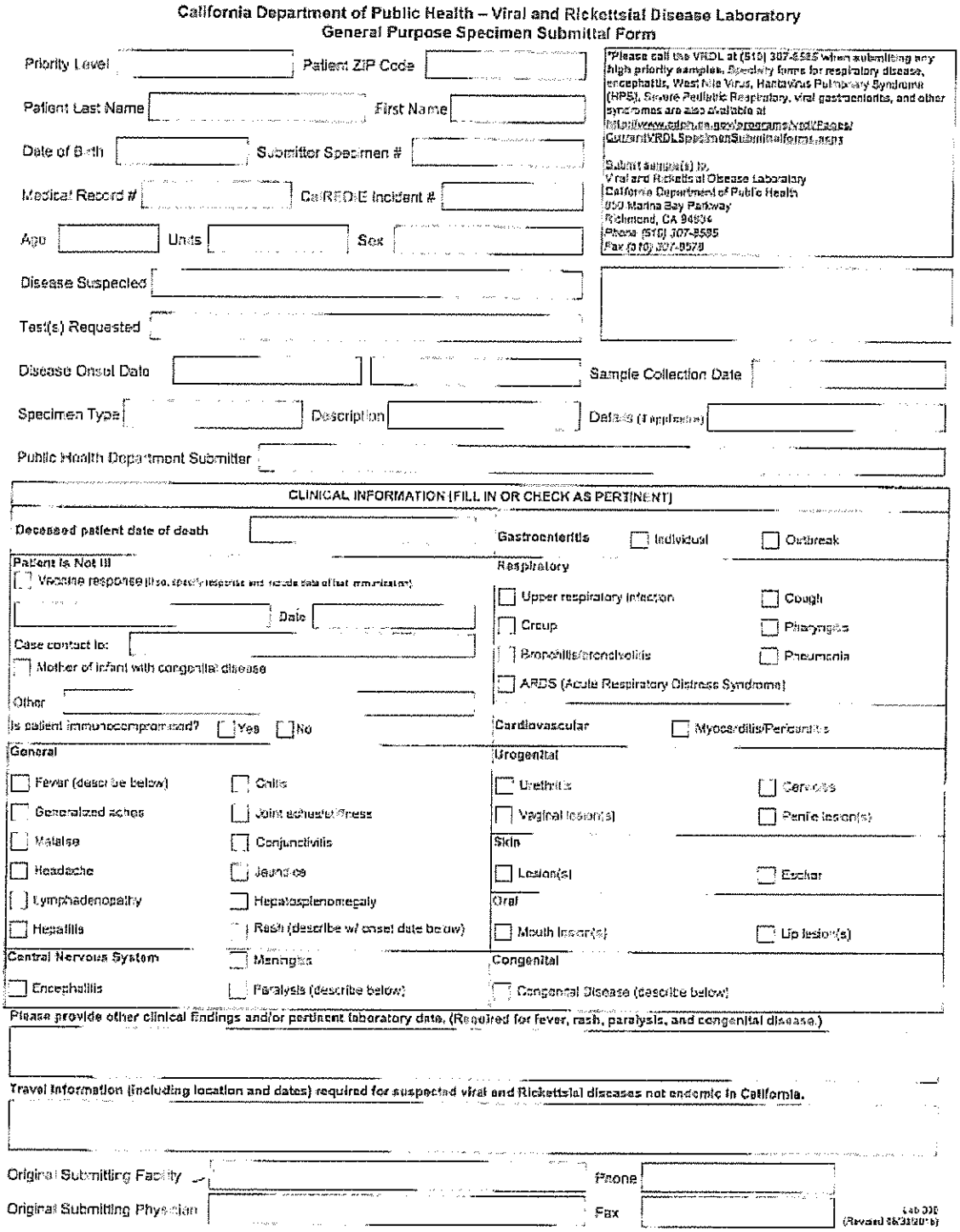
H. **RELATED DOCUMENT(S):**

1. IC Policy: Standard and Transmission Based Precautions
2. IC Policy: Bloodborne Pathogen Exposure Control Plan
3. Employee Health and Wellness Policy Manual: Guidelines for Reporting Exposures Policy

I. **REFERENCE LIST & EXTERNAL LINK(S):**

1. http://www.cdc.gov/zika/about/overview.html
2. https://www.osha.gov/Publications/OSHA3855.pdf
3. http://www.cdc.gov/zika/pdfs/testing_algorithm.pdf
4. Comprehensive Zika Virus Information for Healthcare Providers September 2018 https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/ZikaInformationforHealthProfessionals.aspx
5. Zika Screening Algorithm August 2018 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ZikaAlgorithmPoster.pdf

General Purpose Specimen Submittal Form Sample



California Department of Public Health – Viral and Rickettsial Disease Laboratory
General Purpose Specimen Submittal Form

Priority Level | Patient ZIP Code

Patient Last Name | First Name

Date of Birth | Submitter Specimen #

Medical Record # | CalREDIE Incident #

Age | Units | Sex

Disease Suspected

Test(s) Requested

Disease Onset Date | Sample Collection Date

Specimen Type | Description | Details (if applicable)

Public Health Department Submitter

Please call the VRDL at (510) 307-8585 when submitting any high priority samples. Specialty forms for respiratory disease, encephalitis, West Nile Virus, Hantavirus Pulmonary Syndrome (HPS), Severe Pediatric Respiratory, viral gastroenteritis, and other syndromes are also available at http://www.cdph.ca.gov/programs/vrdl/Pages/CurrentVRDLSpecimenSubmittalForms.aspx

Submit sample(s) to:
Viral and Rickettsial Disease Laboratory
California Department of Public Health
850 Marina Bay Parkway
Richmond, CA 94804
Phone (510) 307-8585
Fax (510) 307-8578

CLINICAL INFORMATION (FILL IN OR CHECK AS PERTINENT)

Deceased patient date of death

Gastroenteritis ☐ Individual ☐ Outbreak

Patient is Not Ill
☐ Vaccine response (If so, specify response and include date of last immunization)
Date
Case contact to:
☐ Mother of infant with congenital disease
Other

Is patient immunocompromised? ☐ Yes ☐ No

Respiratory
☐ Upper respiratory infection ☐ Cough
☐ Croup ☐ Pharyngitis
☐ Bronchitis/bronchiolitis ☐ Pneumonia
☐ ARDS (Acute Respiratory Distress Syndrome)

Cardiovascular ☐ Myocarditis/Pericarditis

General
☐ Fever (describe below) ☐ Chills
☐ Generalized aches ☐ Joint aches/stiffness
☐ Malaise ☐ Conjunctivitis
☐ Headache ☐ Jaundice
☐ Lymphadenopathy ☐ Hepatosplenomegaly
☐ Hepatitis ☐ Rash (describe w/ onset date below)

Central Nervous System
☐ Encephalitis ☐ Meningitis ☐ Paralysis (describe below)

Urogenital
☐ Urethritis ☐ Cervicitis
☐ Vaginal lesion(s) ☐ Penile lesion(s)

Skin
☐ Lesion(s) ☐ Eschar

Oral
☐ Mouth lesion(s) ☐ Lip lesion(s)

Congenital
☐ Congenital Disease (describe below)

Please provide other clinical findings and/or pertinent laboratory data. (Required for fever, rash, paralysis, and congenital disease.)

Travel information (including location and dates) required for suspected viral and Rickettsial diseases not endemic to California.

Original Submitting Facility | Phone

Original Submitting Physician | Fax

LAB 338
(Revised 08/2010*b)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/01	SUBJECT: Credentialing Standards for Catheter-Based Peripheral Vascular* Interventional Procedures
REVISION DATE(S): 09/07, 10/09, 04/17	POLICY NUMBER: 8710-504

Medical Staff Department Approval:	~~05/19~~07/22
Division of Radiology Approval:	~~05/19~~04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/19~~04/23
Administration Approval:	~~07/19~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in catheter-based peripheral vascular interventional procedures.
   a. Catheter-based peripheral vascular interventional procedures include diagnostic angiography, balloon angioplasty, atherectomy, stent placement, and/or thrombolysis of the non-coronary native vasculature or grafts, either arterial or venous. (Refer to Appendix 1)
   b. Criteria for privileging and maintenance of privileges encompass four general areas:
      i. Didactic education in the diagnosis and treatment of patients with peripheral vascular disease;
      ii. Training in the technical aspects of the performance of peripheral vascular interventional procedures;
      iii. Proctoring;
      iv. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Body of Knowledge:
   a. The applicant must have completed an accredited residency program and possess board certification or board eligibility in general internal medicine, diagnostic radiology or general surgery.

   *Non-Cardiac

   b. The applicant must have additional fellowship training, board/CAQ eligibility or certification in interventional radiology, neuroradiology, peripheral vascular surgery or interventional cardiology. Individuals who completed their training prior to the establishment of fellowship programs in the above mentioned disciplines but who are engaged in the active practice of peripheral vascular interventions may be granted privileges established on the basis of guidelines described below with acceptable documentation of success and complication rates.
   c. The applicant must be trained and licensed in fluoroscopy.
2. Basic Training
   a. Applicants for this privilege should have extensive training in the diagnosis and treatment of patients with peripheral vascular diseases to include anatomy, natural history, clinical manifestations, non-invasive assessment, indications and contraindications to catheter-based intervention, risks and benefits of catheter-based

intervention, alternative therapies and recognition and management of complications including catheter directed thrombolysis.

i. For individuals who have completed fellowship training in interventional radiology neuroradiology, or peripheral vascular surgery, ACGME accreditation of their fellowship and documentation of satisfactory completion of the fellowship will provide adequate documentation of this training.

ii. For individuals completing fellowship training in interventional cardiology, there must be both ACGME accreditation of the fellowship training, documentation of satisfactory completion of the fellowship and evidence that the fellowship includes formal didactic education in all aspects of peripheral vascular disease.

iii. For individuals who are practicing peripheral vascular surgery, interventional radiology or interventional cardiology but completed their training prior to the establishment of fellowship training program or inclusion of material on peripheral vascular in those fellowship training programs, documentation of 100 hours of CME approved credit directly pertaining to peripheral vascular disease or the equivalent of 20 days of such course instruction must be provided.

3. Specific Procedural Training and Experience:
   a. Applicants must be knowledgeable regarding appropriate use and options of x-ray imaging techniques for peripheral vascular applications.
   b. Individuals applying for this privilege must be able to document the performance and interpretation of the following:
      i. 100 Diagnostic peripheral arteriograms
      ii. 50 Peripheral arterial angioplasties
      iii. 10 Cases of peripheral stent placement
      iv. 10 Cases of catheter-directed peripheral thrombolysis
   c. The individual must be able to document that he/she was the primary operator (defined as the physician who physically performed the procedure and dictated the operative report) in the above listed procedures. For an individual trained in an approved fellowship, a standard procedural log indicating procedure, the individual's role in the procedure, outcome and complications, will be adequate documentation. For individuals whose training occurred outside of a fellowship setting, the above procedural log must be provided as well as copies of the dictated procedural reports.
4. Proctoring Criteria:
   a. Ten cases performed during the first six months after granting of the privilege(s) will be proctored. These cases should include two cases of peripheral arterial stent placement and two cases of catheter-directed peripheral thrombolysis. The proctor must be privileged for the specific procedure that he/she is proctoring.
5. Reappointment Criteria:
   a. Maintenance of peripheral vascular credentialing requires ongoing experience in performing these procedures with acceptable success and complication rates. In order to qualify for reappointment, the minimum number of cases to be performed in a two-year period for each procedure is:
      1) Peripheral transluminal angioplasty 25 cases
      2) Intravascular stent placement 10 cases
      3) Catheter-Directed Peripheral thrombolysis 10 cases
   b. Reappointment of privileges is also dependent on the active participation in the hospital's Quality Improvement program. The QI program will monitor indications, success rates and complications. Each physician QI data will be reviewed using the same criteria. It is recommended that any practitioner with this privilege maintain a database to record accurate information regarding numbers of procedures, indications and outcomes for quality assessment purposes.

[1]

[1] The criteria above are minimum criteria. Departments or Divisions performing these procedures may elect to require more stringent criteria.

C. **REFERENCE(S):**

1. White R.A. Training and Credentialing Requirements for Endovascular Procedures. Stanford Vascular Symposium: Frontiers in Vascular Disease 1999. (Abstract)
2. Levin DC, Becker GJ, Dorros G, et al. Training Standards for Physicians Performing Peripheral Angioplasty and other Percutaneous Peripheral Vascular Interventions – American Heart Association Medical/Scientific Statement Position Statement. Circulation. 1992;86(4):1348-1350.

APPENDIX I

For the purposes of these standards, a diagnostic angiogram is defined as the percutaneous passage of a catheter into an artery under fluoroscopic guidance with subsequent injection of contrast material and imaging of the entire vascular distribution in question using conventional serial film changers or large field digital imaging systems. For example, peripheral angiography of lower-extremity vessels must image the vessels of both lower extremities from the distal aorta to at least the ankles. Conventional cineradiography or video fluoroscopy alone is not sufficient for the routine recording of peripheral angiographic studies. Measurements of intra-arterial pressure gradients are a useful adjunct and may be necessary to fully assess the significance of vascular occlusive disease as well as the outcome of an interventional procedure.

Angioplasty is defined here as a percutaneous transluminal balloon dilation procedure or similar procedure using an atherectomy, stent or other interventional device. Such a procedure would generally involve percutaneous vascular access, transluminal passage of a balloon catheter or other interventional device and treatment at the appropriate sites. The angioplasty process includes angiographic and hemodynamic documentation of the result and appropriate clinical follow-up during the patient's hospitalization.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 08/96 **SUBJECT: Physician Progress Note**

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 03/16

Department Approval:	~~11/19~~01/23
Division of Psychiatry Approval:	~~03/20~~03/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~04/23
Administration Approval:	~~05/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval Date:	05/20

A. **PURPOSE:**
1. To define expectations for Physician and Allied Health Professional's (AHP's) Progress Notes.

B. **POLICY:**
1. All patients are evaluated on a regular basis by the attending psychiatrist or AHP.

C. **PROCEDURES:**
1. Who May Perform / Responsible: Program psychiatrist
   a. Physicians and AHP's are expected to evaluate patients and complete a progress note at least monthly for all Outpatient Behavioral Health Service (OPBHS) patients.
   b. Physicians must see the patient periodically to oversee the care and ensure quality of services delivered in OPBHS.
   c. Physicians must review AHP's notes to ensure quality care provision.
   d. Open problems on the treatment plan should be addressed in the progress notes.
   e. The progress note is to include a mental status exam, treatment plan, and justification for continued treatment, interval history, medication changes and any changes in diagnosis.
   f. All progress notes are signed electronically in the medical record.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE:	**08/96**	**SUBJECT:**	**Psychiatric Emergencies**
REVISION DATE~~(S)~~:	**05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17**		

Department Approval:	**~~03/19~~01/23**
Division of Psychiatry Approval:	**~~03/20~~03/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~04/23**
Administration Approval:	**~~05/20~~05/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
1. To define the appropriate methods of handling emergency psychiatric situations.

B. **POLICY:**
1. Psychiatric emergencies should be handled by the most qualified person(s) available. Patient and staff safety are of prime concern.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical and Nursing Staff.
2. For minor psychiatric problems (i.e., agitation, oppositional behavior and verbal abuse of others), attempts should be made to isolate the patient from others in the milieu, reduce stimulation (i.e., noise, traffic), and prevent any further escalation of the behavior. Depending on how receptive the patient is to staff intervention, he/she may rejoin the group, take a "time out" or be excused from the Outpatient Behavioral Health Services (OPBHS) for the remainder of the day. The Registered Nurse (RN) may contact the physician/Allied Health Professional (AHP) to evaluate the need for medication adjustment.
3. There's a psychiatric emergency box that contains emergency medications, such as Cogentin, Benadryl, and Naloxone that can be utilized with physician order.
4. For major psychiatric emergencies (e.g., suicide attempt or violence), the safety and welfare of the patient and the group are the primary concerns. Proceed by dialing 911, request the type(s) of assistance needed (e.g., ambulance, police), and remove all other patients from the area. In all cases, the patient's primary and attending psychiatrist (if not the same) are notified and consulted in a timely manner.
5. Physical restraint is not used as a clinical intervention. If a patient becomes violent, 911 must be called immediately.
6. For both major and minor psychiatric emergencies, the Clinical Supervisor, program RN, or designated clinical staff member must assess the need for inpatient hospitalization. This assessment must be made in consultation with the patient's attending psychiatrist. If the attending psychiatrist cannot be reached, the Program Medical Director should be notified and consulted. If the decision is made to evaluate the patient for inpatient hospitalization, the following procedures are followed:
   a. The Clinical Supervisor, RN or Therapist discusses the need for Emergency Department evaluation/inpatient hospitalization with the patient. The patient's family, residential care provider, case manager, and/or primary physician are also notified. If the patient agrees to voluntary admission, the staff makes transportation arrangements and the patient is transported to the Emergency Department. Relevant information from the chart

(psychiatric evaluation, assessments, treatment plan, medication list, etc.) will be sent to the Emergency Department to ensure coordination of treatment.

b. The Community Liaison Coordinator or Therapist maintains contact with patient to ensure continuity of care and a smooth transition back to the OPBHS after discharge from the inpatient unit.

c. When a patient who is suicidal or homicidal, or gravely disabled, will not voluntarily agree to go to the Emergency Department for an evaluation, the local police/Sheriff will be contacted.

7. Psychiatric emergencies that occur after program hours will be directed to call the 911, or a psychiatric Crisis hotline.
8. If the psychiatric emergency results in the patient independently leaving the program during normal treatment hours, the clinical staff notifies the primary and/or attending physician, patient's family, residential care provider, case manager and anyone else actively involved in the patient's care. Police should be notified, if appropriate, and in all cases when the patient may be a danger to self or others, or gravely disabled.
9. All interventions and the results of the interventions must be documented in the patient's medical record by the RN or clinician who managed the psychiatric emergency.

D. **REFERENCE(S):**

1. Involuntary Treatment, Cal. S. 5150 – 5349.5, Chapter 2 (Cal. Stat. 1967).

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE:	05/20	SUBJECT:	Solicitation of Patients / Referrals to Self
REVISION DATE~~(S)~~:			

Department Approval:	~~03/19~~01/23
Division of Psychiatry Approval:	~~03/20~~03/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~04/23
Administration Approval:	~~05/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE

1. To specify parameters with respect to the solicitation of patients or referrals to self.

B. POLICY

1. Who may perform/responsible: OPBHS Clinical Staff
2. Tri-City Medical Center employees will not refer patients, directly or indirectly, to their private practices.
3. Tri-City Medical Center employees will not, directly or indirectly, approach, solicit or suggest to any patient (or patient's representative) that the patient should or must see such employee on any basis outside the program(s) for additional care or therapy, with the exception of those patients who were seen in the therapist's private practice prior to the patient being admitted to the program. In such a case, referrals back to the therapist's private practice is acceptable, if deemed clinically appropriate.
4. If additional treatment is needed, as determined by the treatment team a list of at least two to three qualified therapists will be given to the patient for the patient's selection.
5. An exception to the above is when a patient expresses an interest in seeing the program psychiatrist-. In that case, it would be acceptable for the patient to be treated by the program psychiatrist in their private practice. This would improve continuity of treatment and allow the patient more treatment options.

Tri-City Medical Center	Outpatient Infusion Center ~~Distribution~~
PROCEDURE:	**AMBULATORY INFUSION PUMPS**
Purpose:	To safely manage care of patients who start medication infusion via ambulatory infusion pump.
Supportive Data:	AIPs are commonly used to deliver a variety of medications, including chemotherapy. Patient safety can be jeopardized if the devices are mishandled when filling, programming, attaching and monitoring.
Equipment:	External ambulatory infusion pump

A. **DEFINITIONS:**

1. Ambulatory Infusion Pump (AIP): an external medical device used to deliver medications to a patient in a controlled manner in an outpatient setting.

B. **POLICY:**

1. AIP will be handled according to manufacturer's Operation Manual.
2. All patients will be educated prior to initiation of AIP for drug infusion.
3. Patients will come no less than once weekly for monitoring while on the AIP.
   a. This may include AIP discontinuation appointment.
   b. Monitoring will include inspection of AIP operation and assurance that drug volume is infusing correctly.

C. **PROCEDURE:**

1. Patient Education
   a. Patients will sign a consent outlining the risks and responsibilities.
   b. Patients will be instructed to call prescribing clinician or phone number located on AIP with questions.
   c. For pumps containing chemotherapy: Patients will be instructed on how to use a chemotherapy spill kit and given a kit to take home.
2. Programming
   a. The AIP will be programmed by pharmacy.
      i. The AIP will be reprogrammed and battery will be replaced at each refill.
      ii. AIP will be set to patient lock-out before dispensing to patient.
3. Preparing/Refilling
   a. Pharmacy to dispense/verify the medication or solution used for refills.
   b. Pharmacy is to dispense no more than 5 days' worth of drug infusion to limit risk of drug errors.
   c. Chemotherapy only: Pharmacy will follow Pharmacy Policy: Chemotherapy Prescribing, Processing and Preparation.
      i. This is to include priming line in Compounding Aseptic Containment Isolator.
4. Administration
   a. RN to install reservoir and tubing set into AIP per Operation Manual.
   b. 2 RNs will independently check pump settings against reservoir label before attaching AIP to patient.
   c. Chemotherapy only: Nursing will follow the Oncology Procedure: Chemotherapy Administration.
5. Discontinuing Use of the AIP
   a. Nursing will ensure all drug is delivered before stopping device.
      i. Pharmacy/MD will be notified immediately of any evidence of over or under infusion.

Department Review	Pharmacy & Therapeutics Committee	Division of Oncology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/16, **05/20**	06/16, **10/22**	07/16, **03/23**	08/16, **04/23**	**05/23**	09/16, **n/a**	10/16

b. The AIP will be stopped, clamped and disconnected.
c. Reservoir/tubing set will be disposed of per TCHD policies and procedures.
d. Battery will be disposed of properly.
e. AIP will be cleaned with isopropyl alcohol (all medications) and sodium hypochlorite/neutralizer (hazardous drug leaks/spills only) prior to being returned to pharmacy.

6. Documentation
   a. Drug, dose, rate, total volume to be infused, start and stop time, and actual volume infused (after AIP disconnection) will be recorded on eMAR.
   b. Tracking of AIP serial number dispensed to patient will be performed by entering on Cerner medication label.
7. Maintenance
   a. AIPs shall be sent back to manufacturer upon request for maintenance or according to the manufacturers' maintenance schedule.
      i. The AIP shall not be used if due for maintenance.
   b. Manufacturer will perform all functional verification tests prior to shipping back to TCHD.
   c. If an AIP is suspected to be dysfunctional for any reason, it will be quarantined and sent back to manufacturer for repair.

D. **RELATED DOCUMENT(S):**
1. **Patient Care Services**~~Oncology~~ Procedure: Chemotherapy Administration
2. Patient Care Services Policy: **Medical** ~~Patient Owned/Supplied~~ Equipment Brought Into the Facility
3. Patient Care Services Policy: Chemotherapy Prescribing, Processing and Preparation

E. **REFERENCE(S):**
1. Institute for Safe Medication Practices. 2015. *ISMP*. [ONLINE] Available at: https://www.ismp.org. [Accessed 24 December 15].
2. Infusion Pumps. 2015. *U.S. Food and Drug Administration.* [ONLINE] Available at: http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/GeneralHospitalDevicesandSupplies/InfusionPumps/ [Accessed 24 December 15].

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT:** Medical Record Review

REVISION DATE:

Department Approval:	~~01/17~~, 02/20
Division of Oncology Approval:	~~03/17~~03/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~04/23
Administration Approval:	05/23
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Documentation of assessment findings, procedure/treatment, etc. and appropriate signatures must always be included in the medical record. Pursuant to the hospital policy, the following defines the process used to identify incomplete records and the steps taken to correct deficiencies in the Outpatient Infusion Center (Center).

B. **POLICY:**

1. All charts will be reviewed by the Registered Nurse (RN) or Licensed Vocational Nurse (LVN) for incomplete information after each Center visit prior to transferring to the health information department of the hospital to be scanned into the Cerner system.
2. Incomplete records will be returned to the appropriate physician/Allied Health professional (AHP) for completion.
3. The quality management/improvement process will be utilized as needed to improve the compliance with record completion.

C. **PROCEDURE:**

1. The RN ~~or LVN~~ will review the medical record for incomplete information before the patient is discharged from the clinic.
2. The RN ~~or LVN~~ will communicate the findings to the appropriate person(s).
3. When indicated, the physician/AHP will be notified of the findings to be completed within 24 hours. The completed record will be sent to the health information department for scanning into Cerner.
4. The physician/AHP will be responsible for ensuring that the record is completed.
   a. The RN will work ~~collaboratively with the LVN~~ to achieve record completion.
5. The hospital's medical staff rules and regulations will be followed to complete the medical record.
   a. If the record is not completed within 14 days, the medical director or designee will be notified.
   b. Identified patterns of record deficiencies will be reported to the Medical Staff Office for review.

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 08/06

SUBJECT: RCP Staffing Guidelines in the NICU

REVISION DATE(S): 12/08, 06/11, 05/12, 04/15

Pulmonary Department Approval:	~~02/20~~03/23
Division of Neonatology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. POLICY:

1. To be qualified to work as a Respiratory Care Practitioner (RCP) in the Neonatal Intensive Care Unit (NICU), the RCP must be licensed by the state of California and have evidence of current successful Neonatal Resuscitation program (NRP) certification. Also, these RCP's must have completed additional education requirements as demonstrated by the following: 1) Completion of a formal neonatal respiratory therapy course at an approved school of respiratory therapy that includes didactic and clinical course work; or 2) Completion of a minimum of 20 hours of didactic and four weeks of precepted neonatal clinical experience in a hospital-based course at a facility with a NICU equivalent to a Community or Regional NICU
2. One RCP qualified to work in NICU will be assigned to cover that area every shift, 7 days/week.
3. If there is a neonate on ventilator support, one qualified RCP will be dedicated entirely to the NICU. That is, they will be immediately available to the NICU at all times.
4. If the NICU respiratory patient workload increases (based on acuity of patients or numbers of patients in the NICU) to the point where additional Respiratory staff are needed, the NICU RCP will notify the Lead RCP and/or the Pulmonary manager to obtain the extra staff. The need for additional staff will be determined by the NICU RCP in consultation with the neonatologist, as appropriate. The Lead RCP will reassign other qualified RCPs (those that have a NRP card) to the NICU and/or call in additional staff as needed.

B. REFERENCE(S):

1. California Children's Services (CCS) Policy and Procedure requirements for a Community NICU. California Children's Services Manual of Procedures, 1999.

Tri-City Medical Center
Oceanside, California

RETIRE - Inpatient BHU Services suspended

SECURITY
SECURITY OPERATIONS

SUBJECT: BHU STAT Response (STAT Response to Behavioral Health Services Department)

ISSUE DATE: 04/03
REVIEWED DATE(S): 04/03, 11/06, 3/09, 6/11
REVISION DATE(S): 09/15

POLICY NUMBER: 215

Department Approval Date(s):	~~07/15~~05/20
Environmental Health and Safety Committee Approval Date(s):	~~08/15~~08/20
Administration Approval:	~~10/20~~05/23
Professional Affairs Committee Approval Date(s):	~~09/15~~ n/a
Board of Directors Approval Date(s):	09/15

~~A. PURPOSE:~~

~~1. To establish a set of guidelines for Security Department Personnel to follow in response to a STAT call to the Behavioral Health Services Department.~~

~~B. Y:~~

~~1. All Security Department Personnel will follow the procedures of this policy when responding to a STAT call to the Behavioral Health Services Department.~~

~~C. PROCEDURE:~~

~~1. When the Security Department receives a STAT call to the Behavioral Health Services Department the on-duty Security Department Personnel will respond to the Behavioral Health Services Department in a safe manner.~~

~~2. Once the Security Department Personnel arrive at the Behavioral Health Services Department the responding Officers will immediately report to the Charge Nurse to receive a briefing and overview of the incident and possible resolutions.~~

~~a. The responding Security Department Personnel will find out why the STAT call was placed.~~

~~b. The responding Security Department Personnel will find out who is involved in the incident.~~

~~c. The responding Security Department Personnel will find out what the Charge Nurse would like as the outcome.~~

~~3. The Security Department Personnel will attempt to neutralize the incident by communicating the desires of both the Staff and Patient and to mediate the incident. Security Department Personnel will make every attempt to neutralize the incident without the use of force.~~

~~4. Once the Security Department Personnel arrive at the Behavioral Health Services Department in response to a STAT call and observe an immediate need to intervene due to a violent or dangerous incident the Security Department Personnel will immediately take interventional action to neutralize the incident.~~

~~a. Security Department Personnel will use an appropriate response level (Use of Force) to immediately intervene and neutralize the incident.~~

~~b. Once the incident is neutralized the Security Department will gather all information regarding the incident including what led up to the incident and who was involved in the incident and why the incident occurred.~~

~~c. All Security Department Personnel will meet with the Clinical Staff and participate in the Behavioral Health Services Department critical incident debriefing~~

~~D. NON-COMPLIANCE:~~

~~1. Non-Compliance with any portion of this policy will result in disciplinary action leading up to and or including termination.~~

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07	SUBJECT:	Hyperbaric Oxygen Therapy (HBOT) Consultation
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:	~~05/20~~04/23
Administration Approval:	~~06/20~~05/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. PURPOSE
1. The purpose of this document is to define the procedure for evaluating patients for hyperbaric oxygen treatment.

B. POLICY
1. Patients referred for hyperbaric oxygen therapy (HBOT) will be evaluated for appropriateness for treatment by a qualified HBOT physician prior to treatment.
2. Patients evaluated for treatment will be screened for contraindications.
3. Patients approved for treatment will sign informed consent prior to the first treatment.

C. PROCEDURE
1. Only physicians trained in hyperbaric medicine will supervise/evaluate patients for HBOT. The evaluation will include:
   a. Evaluation for indication
   b. History and physical
   c. Screening for contraindications
   d. Lab testing
   e. Radiology test(s)
   f. $TcPO_2$
2. The HBOT staff will:
   a. Set up patient appointments
   b. Ensure that all proper documents are available and completed by the HBOT physician
   c. Be responsible for obtaining test results for HBOT physician's review
   d. Orient patients approved for treatment
   e. Ensure that the patient or patient's legal representative has given signed consent prior to treatment and that the signed consent is to be had in the medical record.

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

April 20, 2023 – 3:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on April 20, 2023.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director Nina Chaya, M.D.

Also present were:

Dr. Henry Showah, Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Younger and seconded by Director Gleason to approve the agenda as presented. The motion passed unanimously (6-0-0-1) with Director Chaya absent.

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Chavez made an oral announcement of the item listed on the March 31, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: Chief Executive Officer

4. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Sanchez to go into Closed Session at 3:05 p.m. The motion passed (6-0-0-1) with Director Chaya absent.

5. At 5:50 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.

7. Adjournment

Chairperson Chavez adjourned the meeting at 5:55 p.m.

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

April 27, 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 April 27, 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 (via teleconference)

Also present were:

Gene Ma, Chief Executive Officer/Chief Medical Officer
Donald Dawkins, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
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 Gleason and seconded by Director Coulter to approve the agenda as presented. The motion passed unanimously (7-0) by a roll call vote.

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Chavez made an oral announcement of the items listed on the April 27, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Regarding Trade Secrets, two Potential Litigation matters and Conference with Labor Negotiators: Employee organization SEIU.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 2:05 p.m. The motion passed unanimously (7-0) by a roll call vote.

5. At 3:25 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 Reports Involving Trade Secrets and took no action.

The Board in Closed Session took appropriate action regarding two matters of potential litigation and took no action.

Lastly, the Board in Closed Session heard a report on union negotiations 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
April 27, 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 April 27, 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 Marvin Mizell
Director Adela Sanchez

Absent were Directors Tracy M. Younger and Gigi Gleason

Also present were:

Gene Ma, M.D., Interim Chief Executive Officer
Donald Dawkins, Interim Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs officer
Roger Cortez, Chief Compliance Officer
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky Chavez, called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Coulter and seconded by Director Mizell to approve the agenda as presented. The motion passed (5-0-0-2) with Directors Younger and Gleason absent.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Chavez read the Public Comments section listed on the April 27, 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. Introduction

Donald A. Dawkins, Interim Chief Nurse Executive

Dr. Gene Ma, CEO introduced Donald Dawkins, Interim Chief Nurse Executive.

Mr. Dawkins provided a summary of his background and experience. By way of experience, Mr. Dawkins stated he is a nurse of 37 years beginning in Critical Care and moved up progressively both in the hospital as well as the ambulatory services area. Most recently Donald was at Healthcare Corporation of America, one of the larger for-profit healthcare systems. Mr. Dawkins stated he is excited to be back at Tri-City where he worked here between 2004 and 2013.

6. Reports – Information Only

a) Jennifer Paroly– Foundation President

Ms. Jennifer Paroly, Foundation President reported the Foundation is launching a new invigorated Corporate Council. New Foundation Director Steve Harrington is leading the charge and comes with a wealth of experience, information and contacts. The Corporate Council's first event will launch on May 18th. Anyone interested in attending the event may reach out to the Foundation for more information.

Ms. Paroly reported the Foundation granted an additional $180,000 towards the MRI project. The Foundation is also in the process of approving $200,000 towards a new state of the art early lung cancer detection program.

The annual gala is scheduled for November 11, 2023. Additional information will be forthcoming.

Lastly, Ms. Paroly reported previously the Conrad Prebys Foundation gave the Foundation $1.1 million towards the Emergency Department remodel project. They recently hosted a private event in San Diego that Ms. Paroly was invited to attend. She stated Prebys is very interested in helping with patient navigation, prevention and education on healthcare matters. The event provided the opportunity to share needs and challenges facing the district. Ms. Paroly commented on the importance of keeping relationships with our Philanthropic partners going strong.

Chairperson Chavez commented that Ms. Paroly's contacts are amazing and because she has access to these individuals, it opens the doors for us. He expressed his appreciation for her hard work and diligence.

7. March, 2023 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 – $247,385
- Operating Expense – $269,843
- EBITDA – ($4,395)
- EROE – ($15,198)

Mr. Rivas reported on the fiscal year to date Key Indicators

as follows:

- Average Daily Census – 119
- Adjusted Patient Days – 65,130
- Surgery Cases – 4,076
- ED Visits – 40,837

Mr. Rivas reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $27,909
- Operating Expense – $31,548
- EBITDA – ($1,648)
- EROE – ($2,982)

Mr. Rivas reported on the current month Key Indicators as follows:

- Average Daily Census – 123
- Adjusted Patient Days – 7,737
- Surgery Cases - 513
- ED Visits – 4,218

Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

Mr. Rivas provided additional information regarding EBITDA, adjusted patient days and average length of stay. He also answered questions from Chairperson Chavez related to surgery cases.

Dr. Ma commented on contract labor which continues to be a problem. Not only is contract labor more expensive, but it deprives us of long-term staff that know our facility and work closely with our physicians and results in operational inefficiencies and increased costs. Dr. Ma discussed a new program called "Welcome Home" that is being launched to bring back staff who are familiar with the facility, have the skill set and are committed to this District.

7. New Business – None

8. Old Business –

a) Consideration and possible action regarding Labor & Delivery

Dr. Ma stated per discussion at last month's meeting, the Executive Team was asked to explore potential partnership opportunities. Given the significant interest expressed by various organizations including multiple local health systems, and barring any objection from the Board, we will continue to operate Women's and Newborn services, yet allow reasonable time for the Board and administration to complete due diligence and effectively negotiate with a regional partner with the goal of achieving greater clarity on the terms of a definitive affiliation agreement.

Director Sanchez emphasized that the Board and Administration are still working on options and dedicated to doing it correctly,

Dr. Ma stated it is important to clarify that there is a definitive path forward for sustaining this very critical unit here at Tri-City, however the desire is to "rebirth" this unit in a way that is not only sustainable but ultimately results in bringing in additional services that could help solidify Tri-City as the destination facility for Women's' & Newborn Services at Tri-City. Dr. Ma thanked the Board for their support.

Chairperson Chavez stated that it is true that Labor & Delivery costs the district approximately $1 million per month, however the Board has been steadfast in their attempts to keep the unit open.

9. 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.

In the Chief of Staff's absence, Dr. Gene Ma presented the April 2023 Credentialing Actions and Reappointments Involving the Medical Staff. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Coulter approve the 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. Director Mizell seconded the motion

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Mizell and Sanchez**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason and Younger**

b) Consideration of Nurse Practitioner Clinical Privilege Request Form

c) Consideration of Nurse Practitioner Standardized Procedures for the Emergency Department at Tri-City Medical Center

Dr. Ma explained traditionally we had Physician Assistants in the Emergency Department and now we have Nurse Practitioners in a very similar scope.

It was moved by Director Sanchez to approve the Nurse Practitioner Clinical Privilege Request Form and the Nurse Practitioner Standardized Procedures for the Emergency Department. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Mizell and Sanchez**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason and Younger**

10. Consideration of Consent Calendar

It was moved by Director Coulter to approve the Consent Calendar. Director Chaya seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Mizell and Sanchez**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason and Younger**

11. Discussion of items pulled from Consent Calendar - None

12. Comments by Members of the Public –

Chairperson Chavez recognized the following individuals who spoke in support of SEIU-UHW workers:

- Mali Woods
- Amy Fiero
- Kristine Phanthavilay
- Miles Sweeney
- Kim Fluharty
- Matt (of behalf of Rehab Department)
- Brian Ramos
- Angelica Ramos
- Yusef Miller
- Heather Gallo

13. Comments by Interim Chief Executive Officer

Dr. Gene Ma, Interim Chief Executive Officer stated comments made by today's speakers are so heartfelt. He emphasized that we want the best for our employees however we want to ensure the financial viability of the district.

Dr. Ma provided an update on the employee engagement campaign that includes 30-60-90-day targets. Thus far leadership daily rounds have been completed on all departments, seven engagement events have been held including leadership meetings, midnight snack with the C-Suite, "Fun in the Sun" team building event, Lunch & Learn Resource Fare, Medical Staff Town Hall and Employee Leadership Survey. In the coming weeks we will be rolling out even more engagement events, including a morning event called Bagels and Banter and will debut a recruitment retention initiative as well as an Emerging Leaders program that we call "Think Tank". Additionally, we are planning for our first employee Town Hall meeting. Dr. Ma stated that through these events we have learned so much about the impressions of our employees and their perceived role in this organization. With the roll out of our digital suggestion box for patient, employees and medical staff, along with an organizational wide digital employee survey, we expect to gain even more clarity into how we can support our incredible staff in delivering the kind of awesomeness that they bring to

every encounter. In closing, Dr. Ma stated we have accomplished a lot in one month together as a team. Now let's go make month two better!

15. Board Communications

Director Mizell thanked the speakers for their comments and stated it is definitely a balancing act between satisfying union needs and keeping the district sustainable.

Director Coulter echoed Director Mizell's comments.

Director Chaya stated she has been on staff at Tri-City for 10 years and emphasized that everyone is a big part of this organization. She stated that the Board is working diligently to bring in additional revenue for the organization so the hospital to be sustainable as a whole.

Director Sanchez expressed her appreciation to Dr. Ma for the open and sincere communication.

16. Report from Chairperson

Chairperson Chavez thanked the ten (10) individuals who spoke at today's meeting. He encouraged continued participation.

Chairperson Chavez reported on April 18th the Auxiliary distributed 570 scholarships to young people who want to become nurses.

Chairperson Chavez publicly thanked Dr. Ma for changing the environment of the hospital.

Lastly, Chairperson Chavez reported on the CEO search. He reported the recruiters received 88 applicants and after a series of interviews have narrowed the search down to five, one of which is Dr. Ma. First round interviews will be held on May 10 and May 11 and includes a diverse group.

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 HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

May 10, 2023 – 3:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on May 10, 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:

Dr. Henry Showah, Chief of Staff
Jeff Scott, Board Counsel
Neill Marshall, HealthSearch Partners
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Coulter 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 item listed on the May 10, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: Chief Executive Officer

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 3:03 p.m. The motion passed unanimously (7-0).

5. At 8:45 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 took appropriate action concerning the Chief Executive Officer position.

7. Adjournment

Chairperson Chavez adjourned the meeting at 8:46 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

May 11, 2023 – 3:15 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:15 p.m. on May 11, 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:

Dr. Henry Showah, Chief of Staff
Jeff Scott, Board Counsel
Neill Marshall, HealthSearch Partners
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:15 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Mizell to approve the agenda as presented. The motion passed unanimously (7-0).

3. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Chavez made an oral announcement of the item listed on the May 11, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: Chief Executive Officer

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 3:16 p.m. The motion passed unanimously (7-0).

5. At 8:00 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 took appropriate action concerning the Chief Executive Officer position.

7. Adjournment

Chairperson Chavez adjourned the meeting at 8:01 p.m.

Rocky J. Chavez
Chairperson

ATTEST:

Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending April 30, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	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)	36,480.00	07/01/17	07/31/24	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,197.50	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.21	(a)	7,169.67	04/01/23	03/31/25	**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)	15,542.31	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)	22,962.21	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	10/01/22	09/30/25	**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)	2,502.67	02/01/20	04/30/23	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**242,731.14**				

(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 April 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	HEALTHCAREE AD	40623EDU	2,000.00	81189	RABY, CHRISTOPHER

**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.