TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 31, 2023 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Roll Call / Pledge of Allegiance		
3	Approval of Agenda	2 min	Standard
4	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
5	Reports – a) Opioid Stewardship – Ellen Langenfeld, Director of Pharmacy	10 min.	CEO
6	July 2023 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration to approve Risk Management Plan 2023 – Heidi Benson, Clinical Quality Manager	5 min. .	CEO
8	Old Business – a) Consideration to approve Resolution No. 824, A Resolution of Tri-City Healthcare District Authorizing Execution and Delivery of a Promissory Note, Loan and Security Agreement, and Certain Actions in Connection Therewith for a Loan Under the Distressed Hospital Loan Program	5 min.	CEO

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	Chief of Staff - a) Consideration of August 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on August 28, 2023.	5 min. .	COS
10.	Consent Calendar **(1) Board Committee** **(A) Finance, Operations & Planning Committee Director Younger, Committee Chair** (1) Approval of a Healthcare Proctoring agreement with Anton Kusharyou, M.D. for proctoring services for Fiberoptic Endoscopic Evaluation of Swallowing, for a term of three (3) months, beginning July 1, 2023 and ending September 30, 2023, for a total term cost of $2,000. (2) Approval of a Professional Services Agreement Addendum #3 with Tri-City Primary Care Medical Group to add Jamil Alkhaddo, M.D. for a term of 24 months to provide professional services at Tri-City Primary Care Medical Group, Inc. starting October 1, 2023 and ending September 30, 2025, not to exceed a total expenditure of $681,000 over a 24-month term. (3) Approval of an agreement with Marius Viseroi, M.D. for the pulmonary lung nodule program medical directorship for a term of 24 months, beginning September 1, 2023, through August 31, 2025, for a total term cost not to exceed $224,400. (4) Approval of an agreement with Quoc TT. Tran. M.D. and Zhong Zhao, M.D., as co-medical directors of the Utilization Review and DRG Oversight program for a term of 12 months, beginning October 1, 2023 and ending September 30, 2024, at an annual and term cost not to exceed $102,000. (5) Approval of an agreement with Direct Difference to perform abstracting services for a term of 24 months, beginning September 1, 2023 and ending August 31, 2025, for an annual cost of $175,000 and a total term cost of $350,000. (6) Approval of an extension to Amendment #3 and approval of Amendment #4 between TCHD and Colliers International CA, Inc. for a term of 36 months, beginning August 1, 2023 through July 31, 2026. (7) Approval of a System Order and Master Energy Services Agreement between TCHD and BE Development, Inc. for a term of 72 months for an anticipated total cost for the term of $21,569,936, contingent upon final approval from Housing and Urban Development (HUD). (8) Approval of a consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2023 and ending August 31, 2024, for an annual and term cost of $120,000. **(2) Administrative Committees** **a. Patient Care Services Policies & Procedures** 1) Alcohol Withdrawal Symptom Management 2) Chemotherapy Prescribing, Processing and Preparation Policy	10 min.	

	Agenda Item	Time Allotted	Requestor

3) Code Blue Response Plan Policy
4) Continuous Ambulatory Peritoneal Dialysis Procedure
5) Femostop Compression Device Procedure
6) Glucose Monitoring and Exercise Therapy for Diabetic Patients
7) Hazardous Drugs Procedure
8) Medications Brought in by the Patient Policy
9) Patient and Family Education Policy
10) Research Activities: Investigational Medications
11) Spiritual Care of the Patient Policy
12) Ultrasound Guided Peripheral Intravenous Access
13) Unidentified or Confidential Patient 374
14) Ventricular Assist Device: Impella Nursing Care of Patient

b. Administrative 200 District Operations
1) Administrator On Call 281
2) Helicopters on District Policy 207
3) Quality Assessment Performance Improvement (QAPI)
4) Review of Tri-City Medical Center Information by Board Members

c. Administrative 400 Human Resources
1) Identification of Employees and Non -TCHD Employees – 436

d. Emergency Department
1) Deaths of Pediatric Patients Procedure
2) Leave Without Treatment (LWOT), Against Medical Advice (AMA) or Elopement
3) Pediatric Patients, Care of Policy
4) Transfer of Pediatric Patients Procedure

e. Infection Control
1) Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15.0
2) Mold Abatement IC 13.3

f. Medical Staff
1) Credentialing Criteria, Cardiac Rehab 8710-564
2) Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523
3) Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy 8710-523A
4) Credentialing Policy, Expedited Credentialing and Privileging Process 87100-543
5) Credentialing Policy, Processing Medical Staff Applications 8710-543
6) Credentialing Standards for Vertebral Augmentation 8710-534
7) Election Process of Member(s) at Large for Medical Executive Committee 8710-531

g. Surgical Services
1) Age Appropriate Care Policy

h. Wound Care
1) Physician Orders
2) Unit Specific Orientation (RETIRE)

(3) Minutes
a) June 21, 2023 – Special Meeting
b) June 29, 2023 - Regular Meeting

	Agenda Item	Time Allotted	Requestor
	c) June 29, 2023 – Special Meeting d) July 10, 2023 – Special Meeting e) July 27, 2023 – Special Meeting (4) Meetings and Conferences – None (5) Dues and Memberships – None (6) Reports – (Discussion by exception only) a) Dashboard b) Lease Report – (July, 2023) c) Reimbursement Disclosure Report – (July, 2023)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1.5 hours	
17	Adjournment		

Tri-City Medical Center

Risk Management Plan 2023

A. PURPOSE

The Purpose of the Risk Management program is to protect patients, staff and visitors from inadvertent harm. The Risk Management Program is an overarching conceptual framework that is designed to protect the organization's financial assets and intangibles, such as reputation, in the community we serve.

The Risk Management Plan will be the primary tool for implementing the Tri-City Medical Center's (TCMC) overall Risk Management Program. The plan is designed to provide guidance and structure for the organization's clinical and business services that drive the quality patient care while fostering a safe environment.

The focus of the Risk Management Plan is to provide an ongoing, comprehensive and systematic approach to reducing risk exposures or errors. Risk Management activities include identifying, investigating, analyzing, and evaluating risks/errors followed by selecting and implementing the most appropriate methods for correcting, reducing, managing, transferring and/or eliminating the risk/errors.

B. Authority and Role of the Risk Manager

The Risk Manager is empowered by the governing body to implement the functions and activities of the Risk Management Program with the assistance of the patient care and administrative staffs. The governing body has overall responsibility for the effectiveness of the program and providing the necessary resources. The governing body's responsibilities are supported through regular written and verbal communications regarding Risk Management activities that may affect TCMC's finances.

The role of the Risk Manager is to maintain a proactive Risk Management Program in compliance with the provisions of federal, state, and local statutes, applicable scope of practice and regulations. TCMC may participate with voluntary accrediting organizations. The Risk Manager is responsible for creating, implementing, and evaluating the outcome of the Risk Management Plan. These activities should be coordinated with Quality/Performance Improvement, Infection Prevention, Patient Safety and Environment of Care Management. The specific description of the Risk Manager's role can be found in Purpose & Responsibility of Risk Management (8610-293).

The Risk Management Program is formally addressed through designated committees, such as the Patient Safety and Quality Assurance Performance Improvement (QAPI) committees.

C. Scope

Under the direction of the Risk Manager, the Risk Management Program provides for collaboration among all departments, services, and patient care professionals. The Risk Management Program, in collaboration with General Counsel, provides policies, procedures and protocols to address incidents which may create business-related liability, professional liability and general liability. The identification, investigation and management of incidents, harm and other potentially compensable events are a primary responsibility under the Risk Management Plan. This process is directed by the Risk Manager and others who are delegated to participate in the various components of managing adverse events occurring with patients, staff, visitors and organizational assets.

Risk Management will provide consultation, guidance and education to leaders within the following departments, but not limited to, in order to achieve quality care in a safe environment and protect the organization's resources:

a. Administration
b. Billing/Finances
c. Business Development & Marketing
d. Clinical Services
e. General Counsel
f. Health Information Management
g. Human Resources
h. Infection Control
i. Information Technology
j. Materials Management
k. Medical Equipment Management
l. Medical Staff Services
m. Pharmaceuticals and Therapeutics
n. Regulatory Compliance
o. Safety Management/ Environment of Care
p. Security Management

D. Objectives of the Risk Management Program

The objectives of the Risk Management Program include, but are not limited to identification, mitigation, and prevention of risk.

Identification

a. Utilizing risk management strategies to identify and minimize the frequency and severity of near misses.
b. Evaluating systems that can contribute to patient harm or incident.

Mitigation

a. Practice risk avoidance with assessment, pro-active risk analysis, and strategic planning.
b. Reduce the likelihood of risk once identified.
c. Managing adverse events, errors or incidents to minimize financial loss.

Prevention

a. Promoting quality patient care, in collaboration with QAPI.
b. Minimizing the frequency and severity of adverse events, errors and/or incidents.
c. Supporting a non-punitive culture that promotes awareness and empowers staff to identify risk-related issues.
d. Enhancing environmental safety for patients, visitors and staff through participation in environment of care-related activities.
e. Educating stakeholders on emerging and known risk exposures and risk reduction initiatives.
f. Collaborate with Medical Staffing to ensure OPPE/FPPE processes are in accordance with regulatory agencies.

E. GUIDING PRINCIPLES

1. The Risk Management Plan is an overarching conceptual framework that guides the development of a program for risk management.

2. The plan supports TCMC's philosophy that patient safety and risk management are everyone's responsibilities. Teamwork and participation among management, providers and staff are essential for an efficient and effective risk management program.

3. TCMC supports the establishment of a just culture that emphasizes evidence-based, best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified and reported.
    a. Medical and/or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed.
    b. Individuals are still held accountable for compliance with patient safety and risk management practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions will be recommended.

4. The Risk Management Plan stimulates the development, review, and revision of the TCMC's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. These principles provide the foundation for developing and updating key policies and procedures for day-to-day risk management activities, including the following:
    a. Complaint resolution
    b. Event investigation, root-cause analysis, and follow-up
    c. Adverse event disclosure to patients
    d. Failure mode and effects analysis (FMEA)
    e. Trend analysis of events, near misses, and claims
    f. Staff education as it pertains to risk matters

F. Specific Components

The Risk Management Program will include the following components:

1. Incident Reporting
   Incident reporting is intended to provide a systematic, organization-wide program of reporting errors/harm/risk exposures to identify potential future liability. The Risk Management Program includes an incident reporting system that is used to identify, report, track, and trend patterns of events with the potential for causing adverse patient outcomes or other harm to people, property or other assets of TCMC. It is designed to reduce or eliminate preventable harm and property damage, and minimize the financial severity of claims.

   The Risk Manager tracks and trends incident data in order to report those findings to Quality Improvement and/or the appropriate department(s) for follow-up action.

   The responsibility of determining the reportability of incidents to governmental agencies will be the responsibility of the Regulatory Compliance Manager.

2. Reporting Risk Management activities as part of QAPI
   Recognizing that the effectiveness of risk management activities is contingent upon collaboration and integration with QAPI activities, the Risk Manager will work with Quality/Performance Improvement staff to coordinate activities between the two disciplines. This will enhance the identification and resolution of risk and quality issues.

3. Educational Activities

The Risk Manager will provide or facilitate orientation programs for all new employees and contracted staff. Other in-service and training programs will be provided as identified through the ongoing monitoring, tracking and trending of incidents and/or as requested by TCMC staff.

4. Management of patient/patient representative complaints & grievances
   TCMC will have a formal written process for managing patient and family complaints/grievances. This process details response to and resolution of patient/patient representative complaints (Patient Complaints & Grievance Policy (8610-318).

5. Patient Satisfaction
   TCMC will measure patient satisfaction and respond to issues identified in patient satisfaction surveys. The Risk Manager will monitor complaints and report findings related to quality/performance improvement. Of equal importance is Risk Management's direct participation in resolution of complaints, as appropriate.

G. Protection of Risk Management Information Included in QAPI

Risk Management data and information collected should be maintained as a component of TCMC's quality/performance improvement program and reported to QAPI and/or designated subcommittees. This structure may result in findings being considered privileged and confidential and may be distributed outside the quality/performance improvement process only at the direction and with the written consent of legal counsel.

H. Claims Management

The Risk Manager will assist and/or collaborate with General Counsel by, but not limited to:

a. reporting potentially compensable events (PCE), unexpected outcomes or patient complaints to the involved department manager, the insurance carrier as appropriate
b. performing initial and ongoing investigation and interviews
c. documenting activities and correspondence related to the investigation of the incident
d. protecting and preserving patient health information record and/or other documents and evidence for potential future litigation.
e. maintaining confidentiality of protected documents
f. reviewing, vetting and accepting legal service as appropriate
g. timely forwarding subpoenas, summons and complaints to legal counsel

I. **Governing Body Leadership**

The Governing Board is committed to promoting the safety of all patients, staff and visitors. In doing so, the Governing Board authorizes the formal program and adoption of this plan through the Board meeting minutes.

The Governing Body empowers TCMC's Leadership and Management teams with the responsibility for implementing risk management strategies through their leadership, commitment and support.

J. **Review of the Risk Management Plan**

The Risk Management Plan will be reviewed, updated, and approved annually, or as needed. Dated signatures and titles from appropriate parties should be obtained at the time of the approval.

K. **Annual Evaluation of the Risk Management Program**

The Risk Management Program will be evaluated by the governing body annually. Recommendations for enhancements are incorporated into the program prior to final approval.

L. **Confidentiality**

Any and all documents and records that are part of the Risk Management Process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections may include attorney-client privilege, attorney work product, Quality Improvement, and Peer-Review protections.

TCMC, to the extent possible, shall avail itself of the protections afforded by the Patient Safety and Quality Improvement Act of 2005 as well as California Evidence Code section 1157. These protections apply to investigation and documentation of patient safety events, data, and reports—referred to in the law as "patient safety work product"—by creating a patient safety evaluation system, through which the organization produces patient safety work product with the intent of analyzing the data for the purpose of improving patient safety and overall care.

The signatures below represent an acceptance of the Risk Management.

_____ Date Approved: 7/6/23

Dr. Gene Ma, Interim Chief Executive Officer

Tri-City Health Care District

APPROVED: Donald A. Dawkins, CNE

DATE:

Donald Dawkins
Interim Chief Nursing Executive

Date Approved: 7/5/2023

Governing Board:

Date Approved: _____

RESOLUTION NO. 824

A RESOLUTION OF TRI-CITY HEALTHCARE DISTRICT AUTHORIZING EXECUTION AND DELIVERY OF A PROMISSORY NOTE, LOAN AND SECURITY AGREEMENT, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR A LOAN UNDER THE DISTRESSED HOSPITAL LOAN PROGRAM

DISTRESSED HOSPITAL LOAN PROGRAM

WHEREAS, Tri-City Healthcare District (the "Borrower") is a public hospital, as defined in Section 129381 of the Health and Safety Code;

WHEREAS, Borrower does not belong to an integrated health care system with more than two separately licensed hospital facilities.

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed $65,000,000.00 from the California Health Facilities Financing Authority (the "Lender") under the Distressed Hospital Loan Program, with that loan to be funded with the proceeds in the Distressed Hospital Loan Program; and

WHEREAS, the Borrower intends to use the loan in order prevent the closure of the hospital:

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby approves the submission of an application for a loan from the Distressed Hospital Loan Program.

Section 2. Gene Ma, M.D., CEO and Ray Rivas, CFO, Authorized Officer(s) are hereby authorized and directed, for and on behalf of the Tri-City Healthcare District to do any and all things and to execute and deliver any and all documents that the Authorized Officers deems necessary or advisable to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan, is hereby approved. The loan shall be in a principal amount not to exceed **$65,000,000.00,** shall not bear interest, and shall mature 72 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The Authorized Officer(s) are hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially that form, which includes the Loan Funds Disbursement Certification, as well as the redirection of up to twenty percent (20%) of Medi-Cal reimbursements (checkwriter payments) to Lender in the event of default in accordance with Health and Safety Code section 129384, with those changes therein as the Authorized Officers may require or approve, that approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officers are hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with those changes therein as the Authorized Officer(s) may require or approve, that approval to be conclusively evidenced by the execution and delivery thereof.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of Tri-City Healthcare District held on the 31st day of August 2023.

_____

Tracy Younger, Board Chairperson

Attest:

_____

Gigi Gleason, Secretary

SECRETARY'S CERTIFICATE

I, Gigi Gleason, Secretary of Tri-City Healthcare District, hereby regular meeting of the Board of Directors of Tri-City Healthcare District duly and regularly held at the regular meeting place thereof on the day of on the 31st day of August 2023, of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

Ayes:

Noes:

Absent:

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption and is now in full force and effect.

_____

Gigi Gleason, Secretary

Dated:_____

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 21, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/01/2023 – 7/31/2025)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 9/01/2023 through 7/31/2025:

- **BOURLAND, Bryan DO/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **FERNANDEZ, Genaro MD/Cardiology (Sherev Heart and Vascular)**
- **JACOBSEN, Bradley MD/Ophthalmology (San Diego Retina Associates)**
- **MOSER, Michael MD/Teleradiology (StatRad)**
- **MUNSON, Aron MD/Emergency Medicine (TeamHealth)**
- **NOVO, Megan MD/Gastroenterology (North County Gastroenterology)**
- **SONG, Delu MD/Ophthalmology (San Diego Retina Associates)**

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 21, 2023

ADDITIONAL PRIVILEGE REQUEST (Effective 9/01/2023)

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
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
August 21, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/01/2023 – 7/31/2025)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 9/01/2023 through 7/31/2025.

- **KHOUKAZ, Kathlyn PhD/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE – Part 2 of 3
August 21, 2023

ADDITIONAL PRIVILEGE REQUEST (Effective 9/01/2023)

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

- **ALSTEEN, Stephanie, NP** — **Critical Care Med**

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 23, 2023

Members Present	Director Tracy Younger, Director Adela Sanchez, Dr. Henry Showah, Dr. Mohammad Jamshidi-Nezhad
Non-Voting Members Present:	Dr. Gene Ma, CEO; Ray Rivas, CFO; Donald Dawkins, CNE; Roger Cortez, CCO; Jeremy Raimo, COO
Others:	Director Gigi Gleason, Eva England, Tom Moore, Ellen Langenfeld, Mark Albright, Jane Dunmeyer, Miava Sullivan, Barbara Hainsworth
Members Absent:	Director Nina Chaya, Susan Bond

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	Director Younger called the meeting to order at 3:12 p.m.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Dr. Showah, and Dr. Jamshidi-Nezhad seconded, and it was unanimously approved to accept the agenda of August 23, 2023.** **Members:** **AYES: Younger, Sanchez, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Chaya**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes		No minutes to ratify	
5. Old Business	None		
6. New Business			
a. 2023 – Finance, Operations & Planning Committee Meeting	Director Younger conveyed that item 6.a. reflects the remaining 2023 dates		Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Dates	for the Finance, Operations & Planning Committee.		
b. Introduction – Miava Sullivan, FOP Meeting Coordinator	Director Younger introduced Miava Sullivan as the new Finance, Operations & Planning Committee coordinator, replacing Barbara Hainsworth.		Chair
7. Consideration of Consent Calendar:	It has been requested that the following items be pulled for discussion: • Director Younger requested: 7.a. Healthcare Provider Proctoring Services Agreement – Speech Therapy Anton Kushnaryov, M.D. 7.c. Pulmonary Lung Nodule Program-Medical Directorship Marius Viceroi, M.D. 7.d. Co-Medical Director Agreement for Utilization Review / DRG Program Quoc T. Tran, M.D. & Zhong Zhao, M.D.	**MOTION** **It was moved by Director Sanchez, and Dr. Showah seconded, and it was unanimously approved to accept the Consent Calendar for August 23, 2023.** **Members:** **AYES: Younger, Sanchez, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Chaya**	Chair
a. Healthcare Provider Proctoring Services Agreement – Speech Therapy • Anton Kushnaryov, M.D.	Jeremy Raimo gave a brief overview of the purpose and need for this agreement with Dr. Kushnaryov for proctoring services.	**MOTION** **It was moved by Director Sanchez, Dr. Jamshidi-Nezhad seconded, and it was unanimously agreed to authorize the agreement to with Anton Kushnaryov, M.D. for proctoring services for Fiberoptic Endoscopic Evaluation of Swallowing, for a term of 3 months, beginning, July 1, 2023 and ending, September 30, 2023,**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		for a total term cost of $2,000. **Members:** **AYES: Younger, Sanchez, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Chaya**	
b. Professional Services Agreement, Addendum #3 • Tri-City Primary Care-Jamil Alkhaddo, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
c. Pulmonary Lung Nodule Program-Medical Directorship • Marius Viceroi, M.D.	Jeremy Raimo gave a brief overview of the purpose and need for this agreement with Dr. Marius Viseroi as the medical director of the pulmonary lung nodule program.	**It was moved by Dr. Showah, Dr. Jamshidi-Nezhad seconded, and it was unanimously agreed to authorize the agreement to with Marius Viseroi, M.D. for the pulmonary lung nodule program medical directorship for a term of 24 months, beginning, September 1, 2023 through August 31, 2025 for a total term cost not to exceed $224,400.** **Members:** **AYES: Younger, Sanchez, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Chaya**	Jeremy Raimo
d. Co-Medical Director Agreement for Utilization Review / DRG Program • Quoc T. Tran, M.D. & Zhong Zhao, M.D.	On behalf of Angela Luttge, Dr. Ma gave a brief overview of the purpose and need for this agreement with Quoc T. Tran, M.D. and Zhong Zhao, M.D. as co-medical directors of the Utilization Review and DRG Oversight program.	**It was moved by Director Sanchez, Dr. Jamshidi-Nezhad seconded, and it was unanimously agreed to authorize the agreement to with Quoc T. Tran, M.D. and Zhong Zhao, M.D. as co-medical directors of the Utilization Review and DRG Oversight program for a term of 12 months, beginning October 1,**	Angela Luttge

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		2023 and ending September 30, 2024, at an annual and total term cost not to exceed $102,000. **Members:** **AYES: Younger, Sanchez, Showah, Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Chaya**	
e. Cardiology Abstracting Services Proposal • Direct Difference		**Approved via Consent Calendar**	Eva England
f. Commercial Real Estate Listing Agreement Amendment • Colliers International CA, Inc.		**Approved via Consent Calendar**	Jeremy Raimo
g. Billing Services Agreement • BE Development, Inc. (Bloom Energy Corp.)	Jeremy Raimo conveyed that when this write-up was initiated, the area to denote this as a "new agreement" was not documented. Miava Sullivan to amend the original write-up document.	**Approved via Consent Calendar**	Benito Oporto / Jeremy Raimo
h. Consulting Agreement – Governmental Affairs • Robert E. Hertzka, M.D.	Dr. Ma advised the committee that the monthly and term dollar amounts for this write-up should be modified to reflect $10,000 per month for an overall term amount of $120,000. Miava Sullivan to amend the original write-up document.	**Approved via Consent Calendar**	Dr. Gene Ma
8. Financials:	Ray Rivas presented the financials ending July 30, 2023 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 25,410 Operating Expense $ 29,701		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EBITDA $ (2,442) EROE $ (3,585) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 122 Adjusted Patient Days 7,512 Surgery Cases 418 ED Visits 4,387 **Graphs:** • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Acute Average Length of Stay • TCMC-Emergency Department Visits		
a. Dashboard	No discussion		Ray Rivas
10. Comments by committee members	Director Sanchez conveyed her gratitude to those chiefs in attendance for their hard work and diligence on behalf of the hospital, during a very challenging medical and economic period.		Chair
11. Date of next meeting	Thursday, September 20, 2023		Chair
13. Adjournment	Meeting adjourned 3:38 p.m.		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
HEALTHCARE PROVIDER PROCTORING SERVICES AGREEMENT-SPEECH THERAPY

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

Physician's Name: Anton Kushnaryov, M.D.

Area of Service: Speech Therapy

Term of Agreement: 3 Months, Beginning, July 1, 2023 - Ending, September 30, 2023

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

Rate/Day	Term	Total Term Cost
$200 / per hour	Up to 10 sessions	**$2,000**

Description of Services/Supplies:

- Proctoring services for Fiberoptic Endoscopic Evaluation of Swallowing

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:		Yes	X	No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize a Healthcare Proctoring Services Agreement with Anton Kushnaryov, M.D. for proctoring services for Fiberoptic Endoscopic Evaluation of Swallowing, for a term of 3 months, beginning, July 1, 2023 and ending, September 30, 2023, for a total term cost of $2,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
PROFESSIONAL SERVICES AGREEMENT - ADDENDUM #3

Type of Agreement		Medical Directors		Panel	X	Other: Addendum #3
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Tri-City Primary Care Medical Group - Jamil Alkhaddo, M.D.

Area of Service: Endocrinology

Term of Agreement: 24 months, Beginning October 1, 2023 through September 30, 2025

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

Terms of the Engagement:	Proposal Costs:
Monthly Professional Stipend	$24,166 per month for 2 years ($290,000 annually - $580,000 total)
Monthly Benefit Stipend	$1,583.33 per month for 2 years ($38,000 total)
Sign-on Advance	$48,000 - 1/2 upon start date & 1/2 after 90 days
Relocation Assistance	$15,000 with receipts
Total Amount of Request:	**$681,000**

Description of Services/Supplies:

- Physician to provide professional endocrinology services through Tri-City Primary Care Medical Group

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:		Yes	X	No

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that the Finance Operations and Planning Committee authorize through a Professional Services Agreement Addendum #3 with Tri-City Primary Care Medical Group to add Jamil Alkhaddo, M.D. for a term of 24 months to provide professional services at Tri-City Primary Care Medical Group, Inc. starting October 1, 2023 and ending September 30, 2025. Not to exceed a total expenditure of $681,000 over a 24-month period.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
PULMONARY LUNG NODULE PROGRAM - MEDICAL DIRECTORSHIP

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

Physician's Name: Marius Viseroi, M.D.

Area of Service: Pulmonary Lung Nodule Program

Term of Agreement: 24 months, Beginning, September 1, 2023 and Ending, August 31, 2025

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

Rate	Term	Total Cost
$3,750 per month, Medical Director	24 months	$90,000
$350 / Encounter Up to 16 Encounters / per month	24 months	$134,400
	Total Term Cost	**$224,400**

Description of Services/Supplies:

- Medical Direction of new Pulmonary Lung Nodule Program
- Planning, preparation, mapping, referral coordination of each patient encounter undergoing endobronchial ultrasound (EBUS) and/or Ion Procedures for nodule biopsy and excision

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, Chief Operating Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize an agreement with Marius Viseroi, M.D. for the pulmonary lung nodule program medical directorship for a term of 24 months, beginning, September 1, 2023 through August 31, 2025 for a total term cost not to exceed $224,400.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
CO-MEDICAL DIRECTOR AGREEMENT FOR UTILIZATION REVIEW/DRG PROGRAM

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

Vendor's Name: Quoc T. Tran, M.D. & Zhong Zhao, M.D.

Area of Service: Utilization Review/DRG Program

Term of Agreement: 12 months, Beginning October 1, 2023 – Ending, September 30, 2024

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

Rate/Hour	Maximum Hours per Month per Medical Director	Hours per Year Not to Exceed per Director	Total Monthly Cost Not to Exceed	Total Annual/Term Cost Not to Exceed
$170	25	300	$8,500	**$102,000**

Position Responsibilities:

- CMS "Conditions of Participation" and California Title XXII require the Utilization Review (UR) Committee Ensures DRG program compliance.
- Provide Co-Medical direction of the UR Committee
- Physician consultation for peer to peer reviews, denial reviews, and utilization review
- Works directly with the Director of Case Management/Social Services in overseeing multidisciplinary Rounds, physician education and provider feedback.

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: Angela Luttge, Director-Case Management-Social Services / Dr. Gene Ma, Chief Executive Officer

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Quoc T. Tran, M.D. and Zhong Zhao, M.D. as co-medical directors of the Utilization Review and DRG Oversight program for a term of 12 months, beginning October 1, 2023 and ending September 30, 2024, at an annual and total term cost not to exceed $102,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
ABSTRACTING SERVICES PROPOSAL

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

Vendor's Name: Direct Difference

Area of Service: Abstracting Service / Quality

Term of Agreement: 24 months, Beginning, September 1, 2023 – Ending, August 31, 2025

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$14,583.33	$175,000	**$350,000**

Description of Services/Supplies:

- Abstraction of STEMI, CAD, TAVR, Watchman cases
- Abstraction of CABG cases for CCORP and STS (mandatory abstraction for the State)
- Abstraction of sepsis and Quality data for Leap

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

Person responsible for oversight of agreement: Eva England, Sr. Director Ancillary Services & Operations / Dr. Gene Ma, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Direct Difference to perform abstracting services for a term of 24 months, beginning, September 1, 2023 and ending, August 31, 2025 for an annual cost of $175,000, and a total term cost of $350,000.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
BILLING SERVICES AGREEMENT

Type of Agreement		Medical Directors		Panel	X	Other: Microgrid installation & energy purchase
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor Name: BE Development, Inc. (Bloom Energy Corp.)

Area of Service: Electricity Provision Microgrid Installation

Term of Agreement: 6 years, commencing with system installation and activation (2 agreements): System Order and Master Energy Services Agreement

Maximum Totals:

Yearly Cost	72 Month (Term) Cost
$3,594,989	**$21,569,936**

Responsibilities:

- Company to install microgrid energy delivery system at no cost to District
- District to be exclusive purchaser of electricity derived from microgrid system
- Average annual cost savings to District over 6-year term $331,513
- Total cost for the term is dependent electricity usage

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

Person responsible for oversight of agreement: Benito Oporto-Director of Engineering / Jeremy Raimo, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreements (System Order and Master Energy Services Agreement) between TCHD and BE Development, Inc. for a term of 72 months for an anticipated total cost for the term of $21,569,936, contingent upon final approval from Housing and Urban Development (HUD).

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Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
COMMERCIAL REAL ESTATE LISTING AGREEMENT AMENDMENT

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

Company Name: Colliers International CA, Inc.

Area of Service: Administration, Medical Office Space

Term of Agreement: Extension from March 24, 2022 through July 31, 2023 to Amendment #3 and Amendment #4, from, August 1, 2023 through, July 31, 2026 (3 years)

Maximum Totals:

(Term) Cost (% by lease term duration)
6% for years 1 - 5
4% for years 6 - 10
2.5% for years 11 - 30

Responsibilities:

- Market TCHD vacant space to prospective tenants
- Recommend and negotiate lease terms with District Leadership and outside parties for best interest of District
- Provide Fair Market Value Analyses on an as needed basis

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the extension to amendment three and approval of amendment four between TCHD and Colliers International CA, Inc. for a term of 36 months beginning August 1, 2023 through July 31, 2026.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 23, 2023
CONSULTING AGREEMENT – GOVERNMENTAL AFFAIRS

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

Vendor's Name: Robert E. Hertzka, M.D.

Area of Service: Governmental Affairs

Term of Agreement: 12 months, Beginning, September 1, 2023 – Ending, August 31, 2024

Maximum Totals:

Monthly Fee	Total Term Cost
$10,000	**$120,000**

Description of Services/Supplies:

- Consulting services in the pursuit of legislative, regulatory, or financing objectives that support the interests of Tri-City Healthcare District
- Collaborate in close partnership with administration and Board to develop a strategic roadmap for governmental and legislative priorities
- Provide guidance and recommendations with respect to legislative advocacy on behalf of the District
- Be available as a resource to the Board and Hospital with respect to governmental affairs

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

Person responsible for oversight of agreement: Dr. Gene Ma, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the consulting agreement with Robert E. Hertzka, M.D. for Governmental Affairs for a term of 12 months, beginning September 1, 2023, and ending August 31, 2024, for an annual and term cost of $120,000.

ADMINISTRATION CONSENT AGENDA
August 21st, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Alcohol Withdrawal Symptom Management	3 year review	Forward to BOD for Approval
2. Chemotherapy Prescribing, Processing, and Preparation Policy	3 year review, practice change	Forward to BOD for Approval
3. Code Blue Response Plan Policy	3 year review, practice change	Forward to BOD for Approval
4. Continuous Ambulatory Peritoneal Dialysis Procedure	3 year review	Forward to BOD for Approval
5. Femostop Compression Device Procedure	3 year review	Forward to BOD for Approval
6. Glucose Monitoring and Exercise Therapy for Diabetic Patients	3 year review, practice change	Forward to BOD for Approval
7. Hazardous Drugs Procedure	3 year review, practice change	Forward to BOD for Approval
8. Medications Brought In By the Patient Policy	3 year review	Forward to BOD for Approval
9. Patient and Family Education Policy	3 year review	Forward to BOD for Approval
10. Research Activities: Investigational Medications	3 year review, practice change	Forward to BOD for Approval
11. Spiritual Care of the Patient Policy	3 year review, practice change	Forward to BOD for Approval
12. Ultrasound Guided Peripheral Intravenous Access	3 year review, practice change	Forward to BOD for Approval
13. Unidentified or Confidential Patient 374	3 year review, practice change	Forward to BOD for Approval
14. Ventricular Assist Device: Impella Nursing Care of Patient	Practice change	Forward to BOD for Approval
Administrative 200 District Operations		
1. Administrator on Call 281	3 year review	Forward to BOD for Approval
2. Helicopters on District Policy 207	3 year review, practice change	Forward to BOD for Approval
3. Quality Assessment Performance Improvement (QAPI) Plan	NEW	Forward to BOD for Approval
4. Review of Tri-City Medical Center Information by Board Members 210	3 year review	Forward to BOD for Approval
Administrative 400 Human Resources		
1. Identification of Employees and Non-TCHD Employees - 436	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
August 21st, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Emergency Department		
1. Deaths of Pediatric Patients Procedure	3 year review	Forward to BOD for Approval
2. Leave Without Treatment (LWOT), Against Medical Advice (AMA) or Elopement	3 year review	Forward to BOD for Approval
3. Pediatric Patients, Care of Policy	3 year review	Forward to BOD for Approval
4. Transfer of Pediatric Patients Procedure	3 year review	Forward to BOD for Approval
Infection Control		
1. Influx of Infectious Patients Epidemic Influenza or Other Respiratory Transmitted Disease IC 15.0	3 year review	Forward to BOD for Approval
2. Mold Abatement IC 13.3	3 year review	Forward to BOD for Approval
Medical Staff		
1. Credentialing Criteria, Cardiac Rehab 8710-564	3 year review	Forward to BOD for Approval
2. Credentialing Criteria, Chronic Non-Healing Wound Care 8710-523	3 year review	Forward to BOD for Approval
3. Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy, 8710-523A	3 year review	Forward to BOD for Approval
4. Credentialing Policy, Expedited Credentialing and Privileging Process 8710-550	3 year review	Forward to BOD for Approval
5. Credentialing Policy, Processing Medical Staff Applications 8710-543	3 year review	Forward to BOD for Approval
6. Credentialing Standards for Vertebral Augmentation 8710-534	3 year review	Forward to BOD for Approval
7. Election Process of Member(s) at Large for Medical Executive Committee 8710-531	3 year review, practice change	Forward to BOD for Approval
Surgical Services		
1. Age Appropriate Care Policy	3 year review	Forward to BOD for Approval
Wound Care		
1. Physician Orders	3 year review	Forward to BOD for Approval
2. Unit Specific Orientation	RETIRE	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**07/16**	**SUBJECT:**	**Alcohol Withdrawal Symptom Management**
REVISION DATE~~(S)~~:	**08/20**		

Patient Care Services Content Expert Approval:	**~~06/20~~04/23**
Clinical Policies and Procedures Approval:	**~~06/20~~05/23**
Nursing Leadership Approval:	**~~07/20~~06/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/20~~07/23**
Administration Approval:	**~~08/20~~08/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **DEFINITION(S):**
1. Alcohol Use Disorders Identification Test (Audit-C): A 3-item alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorders. Generally, the higher the Audit-C score, the more likely it is that the patient's drinking is affecting their health and safety.
2. Clinical Institute Withdrawal Assessment Scale for Alcohol Revised (CIWA-Ar): A 10-item scale for assessment and management of alcohol withdrawal. A summation of the scores correlates to the severity of alcohol withdrawal.

B. **POLICY:**
1. All patients shall be screened for alcohol use on admission.
   a. If a patient is identified on admission as currently consuming alcohol which puts them at risk for experiencing alcohol withdrawal symptoms during hospitalization, the nurse will discuss with physician and obtain orders for management of withdrawal symptoms.
2. Patients shall be assessed each shift for signs/symptoms of alcohol withdrawal.
   a. If patient exhibits signs/symptoms of alcohol withdrawal, the patient will be assessed using the CIWA-Ar scale.
      i. Based on the CIWA-Ar score, the nurse will contact physician and obtain orders for management of withdrawal symptoms.
         1) If patient is pregnant or lactating, review appropriateness of medications with physician.
3. If a patient has a CIWA-Ar score of greater than or equal to 8, the patient requires more frequent monitoring and a higher level of care (ie: Telemetry or Intensive Care Unit).

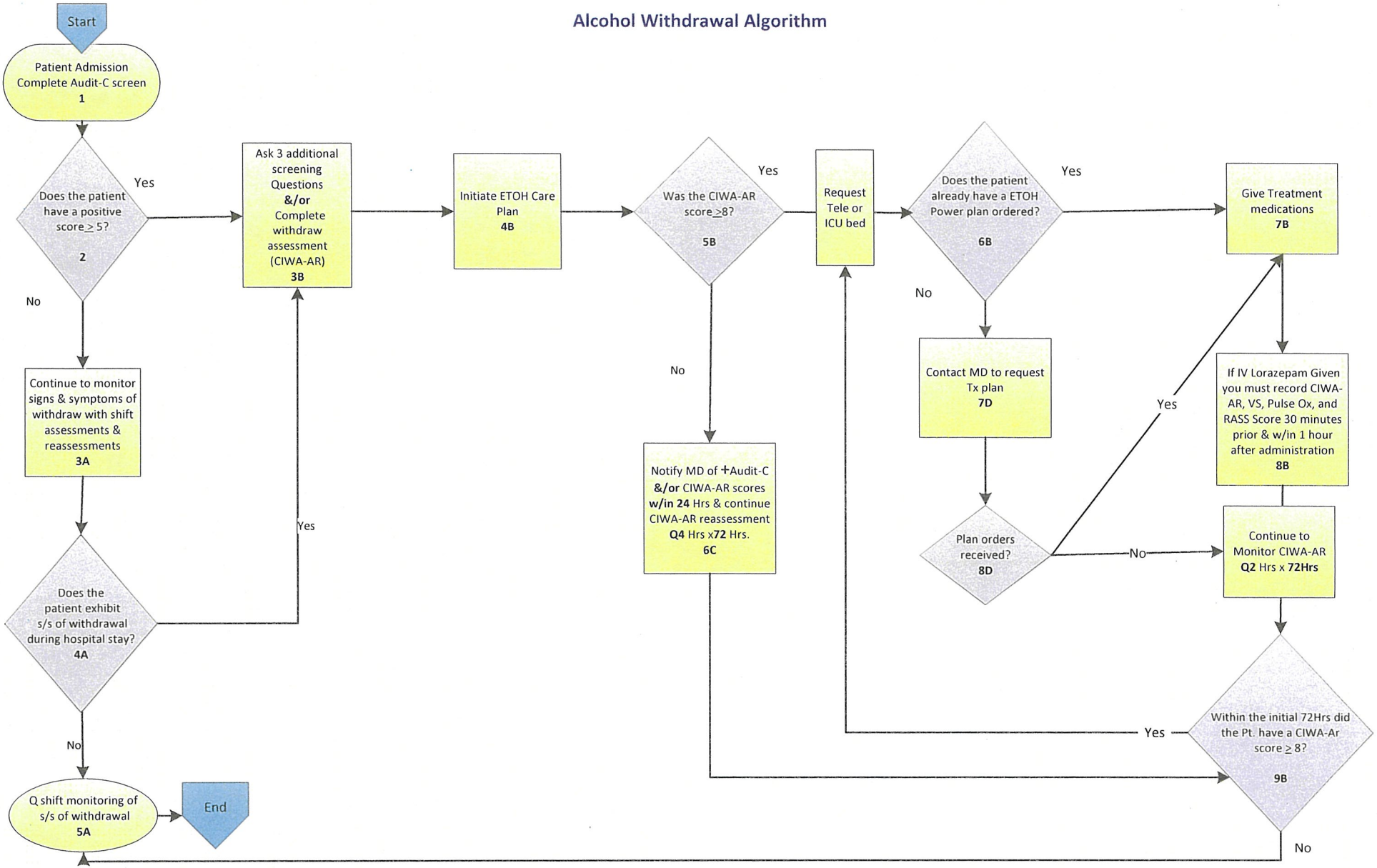
C. **PROCEDURE:**
1. Screen the patient for alcohol use by completing the Audit–C screen in the electronic health record (EHR) upon admission.
   a. If a patient scores less than 5, monitor patient for signs and symptoms of alcohol withdrawal with shift assessments and reassessments.
   b. If a patient scores greater than or equal to 5:
      i. Ask 3 additional screening questions.
      ii. Initiate the Adult Alcohol Withdrawal Interdisciplinary Plan of Care (IPOC).
      iii. Complete the CIWA–Ar in the EHR.
2. CIWA-Ar scores upon admission or during shift assessment,
   a. If the CIWA- Ar is less than 8:

i. Notify the MD of the positive Audit-C and or CIWA-Ar scores within 24 hours.
ii. Continue CIWA-Ar reassessment every 4 hours times 72 hours.
iii. If the patient has 3 consecutive CIWA-Ar scores less than 8, monitor every shift for signs and symptoms of alcohol withdrawal.

b. If the CIWA-Ar score is greater than or equal to 8:
i. Request a higher level of care (i.e. Telemetry or Intensive Care Unit) bed.
ii. Contact MD to request treatment plan if none present.
iii. Monitor CIWA-Ar every 2 hours times 72 hours.
iv. Additional requirements for Intravenous (IV) Lorazepam
1) Assess prior to and 1 hour after administration
a) CIWA-Ar
b) Vital signs
c) Oxygen saturation per Pulse Oximetry
d) Richmond Agitation Scale Score (RASS)

D. **RELATED DOCUMENT(S):**
1. Alcohol Withdrawal Algorithm

Alcohol Withdrawal Algorithm



Notify MD if:

1) Patient exhibits signs/symptoms of delirium tremens (DTs)
2) Vital Signs or RASS score are out of range
3) During the Treatment Plan the patient has "3" consecutive scores >8, for possible increase in PRN dosing

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**11/11**	**SUBJECT:**	**Chemotherapy Prescribing, Processing and Preparation**
REVISION DATE~~(S)~~:	**05/13, 06/14, 07/15, 09/16, 09/19**		
Patient Care Services Content Expert Approval:	~~11/17~~10/22		
Clinical Policies & Procedures Committee Approval:	~~12/17~~11/22		
Nursing Leadership ~~Executive Committee~~ Approval:	~~01/18~~01/23		
Division of Oncology Approval:	~~03/19~~03/23		
Pharmacy & Therapeutics Committee Approval:	~~05/19~~05/23		
Medical Executive Committee Approval:	~~06/19~~06/23		
Administration Approval:	~~07/19~~08/23		
Professional Affairs Committee Approval:	n/a		
Board of Directors Approval:	09/19		

A. **PURPOSE:**

1. All chemotherapy prescribed for Tri-City Healthcare District (TCHD) patients will be processed according to the following policy to ensure accuracy and safety in prescribing, processing and preparation of chemotherapeutic agents.

B. **CHEMOTHERAPY PRESCRIBING PROCEDURE:**

1. **The term "c~~C~~hemotherapy"** will encompass anti-neoplastic agents used to treat cancer including monoclonal antibodies, oral tyrosine kinase inhibitors as well as traditional cytotoxic chemotherapy.
2. Orders written for chemotherapy agents shall meet the following criteria:
   a. Signed by a physician (medical doctor [MD] or Doctor of Osteopathic Medicine [DO]) of Oncology or those who have been granted privileges to order chemotherapy ~~before processed by pharmacy~~
      i. ~~Note:~~ Pharmacy will not accept orders from Nurse Practitioners (NPs) or Physician Assistants (PAs) for any chemotherapy agent regardless of indication or use.
   b. Accompanied by a copy and/or name of protocol used in determining the prescribed regimen if required for verification purposes by pharmacy.
   c. Telephone/verbal orders between physicians and physician assistant/nursing will not be accepted unless order is to hold or stop chemotherapy administration.
   ~~b.~~**d. Changes to orders regarding chemotherapy drug name, dosing parameters, route, or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician on the Chemotherapy Order Form.**
      i. Exception: A pharmacist may use discretion to modify an existing Chemotherapy Order Form with telephone/verbal order read back (ie. Carboplatin dose calculations using the Calvert equation)
~~2.~~**3. Orders must be w~~W~~**ritten on ~~either the pre-printed~~ **approved TCHD** ~~Standard~~ Chemotherapy Order Form**s.** ~~or the regimen specific order forms.~~
   a. Exception: TCHD Outpatient Infusion Center (OIC) may use ~~institution~~ **clinic** specific chemotherapy orders.
   b. Outpatient chemotherapy orders **and orders from other institutions** are invalid for use upon hospital admission. Orders must be rewritten ~~either~~ on ~~the~~ **TCHD** ~~pre-printed Standard~~ Chemotherapy Order Form ~~or the regimen specific order forms~~.
4. **New orders must be written prior to each new chemotherapy cycle.**

~~b.~~**a. Exception: Outpatient Infusion Center Orders will be reviewed and re-signed yearly.**

~~Telephone and verbal orders between physicians and physician assistant/nursing will not be accepted unless order is to hold or stop chemotherapy administration.~~
~~Changes to orders regarding chemotherapy drug name, dosing parameters, route, or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician on the Chemotherapy Order Form.~~
~~Exception: A pharmacist may modify an existing Chemotherapy Order Form with verbal/telephone order read back.~~
~~Pharmacists may shorten multi day continuous infusions from over 24 hour to 22 hours for logistical purposes without a verbal/telephone order read back.~~

~~i. Corrected carboplatin doses based on the Calvert equation may be calculated by the pharmacist and documented on the original order. The pharmacist must read back the change to the physician.~~

~~3.~~**5.** Complete orders must include:

a. Patient's full name and second patient identifier ~~(medical record number or date of birth [DOB]) per Patient Care Services Policy: Identification, Patient.~~
b. Date **the order is written**
c. Diagnosis
d. Regimen name **or p~~P~~rotocol name**
e. **C**ycle number **and day, when applicable**
f. Written using the generic name of the agent ~~and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names~~
   i. Free of any number prefixes such as "5-fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements
g. Doses may not include trailing zeros; ~~use~~ a leading zero (0) **must be used** for doses less than one (1) mg
h. The dose calculation consisting of:
   i. The calculation methodology
      1) Doses will use the metric system and include dose/m^2, dose/kilogram or **Area Under Curve (**AUC**)** when appropriate. The actual calculated dose will be included
      2) ~~Written~~**Doses will be written** as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5) ~~never written as total amount needed per course of therapy as this could be interpreted as daily dose~~
      3) For carboplatin calculated with the Calvert equation:
         a) ~~Target area under curve (AUC)~~
         b) Creatinine Clearance and equation used to calculate if different than Cockcroft-Gault
         c) Serum Creatinine used if different than current lab
         d) Actual, ideal or adjusted weight used to calculate dose
         ~~Height, weight and any other variables used to calculate the dose (i.e. body surface area [BSA])~~
   ii. Variables used for calculation methodology including height and weight
   iii. The frequency at which these variables are to be measured
      1) In the absence of parameters for frequency of remeasurement for height and weight, the following will be used:
         a) Inpatient chemotherapy: ~~height and weight sh~~**all** ~~ould be~~ measured within 48 hours from the start of the new cycle. **Height ~~shall~~should be measured with each new hospital admission.**

b) Outpatient chemotherapy: weight sh**all**~~ould~~ be measured at the beginning of each new cycle. Height **should**~~must~~ be measured at the beginning of each new regimen.

iv. The changes in values that prompt confirmation of dosing

1) In the absence of parameters for changes in dose based on weight and height, the following shall be used:

a) Cytotoxic chemotherapy: the difference of the calculated dose based on the current height and weight is greater than 5% of treatment plan dose.

b) Monoclonal antibodies: the difference of the calculated dose based on the current height and weight is greater than 10% of treatment plan dose.

i. Date of administration

j. Route of administration

k. Allergies

l. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)

~~e.~~m. Parameters that would require holding or monitoring the dose, for example, laboratory values, diagnostic test results and patient's clinical status

i. In the absence of treatment parameters, the lab values of ANC ≤ 1500 cells/µL, platelets ≤ 100,000/uL total bilirubin ≥ 1.4 mg/dL, CrCl <60 mg/dL (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved by physician before preparation of dose.

ii. Guidelines for timing of labs:

1) In chemotherapy naïve patients (no prior chemo) lab results should be no older than seven (7) days.

2) For patients currently receiving chemo with the following frequencies:

a) Every seven (7) days – lab results should be within two (2) calendar days

b) Every fourteen (14) days~~)~~ and beyond – lab results can be within three (3) calendar days (i.e. 72 hours)

3) Daily (consecutive days of chemo) – labs should be drawn on day one (1).

4) Labs drawn with alternative timing may be accepted at the pharmacists' discretion.

iii. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C will be calculated and included on the order.

~~f. Protocol name~~

~~Appropriate criteria to treat (i.e based on relevant laboratory results and toxicities)~~
~~Allergies~~
~~Reference to the methodology of the dose calculation or standard of practice equations (i.e. calculation of creatinine clearance)~~
~~For carboplatin calculated with the Calvert equation this includes:~~
~~Target area under curve (AUC)~~
~~Creatinine Clearance and equation used to calculate if different than Cockcroft-Gault~~
~~Serum Creatinine used if different than current lab~~
~~Actual, ideal or adjusted weight used to calculate dose~~
~~Height, weight and any other variables used to calculate the dose (i.e. body surface area [BSA])~~
~~Inpatient chemotherapy: height and weight should be measured within 48 hours from the start of the new cycle.~~

~~Outpatient chemotherapy: weight should be measured at the beginning of each new cycle. Height must be measured at the beginning of each new regimen.~~

~~Dosage~~

~~Doses may not include trailing zeros; use a leading zero (0) for doses less than one (1) mg~~

~~Doses will use the metric system and include dose/m^2, dose/kilogram or AUC when appropriate. The actual calculated dose will be included~~

~~Written as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5) never written as total amount needed per course of therapy as this could be interpreted as daily dose~~

~~Route and rate (if applicable) for administration~~

n. Sequence of drug administration, when applicable

o. ~~Length of infusion~~**Rate of drug administration,** ~~(~~**when**~~if~~ applicable~~)~~

p. An explanation of time limitation, such as the number of doses for which the order is valid.

~~g. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)~~

~~h. Sequence of drug administration (if applicable)~~

~~i. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C~~

~~j. Written using the generic name of the agent and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names~~

~~4. Free of any number prefixes such as "5 fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements~~ ~~New orders must be written prior to each new chemotherapy cycle.~~

~~a. Exception: Outpatient Infusion Center Orders must be reviewed and re-signed yearly. Accompanied by a copy and/or name of a readily available reference or the protocol name and number used in determining the prescribed regimen if the regimen is unfamiliar to the pharmacist.~~

~~5.~~**6.** Exceptions

a. Physicians that are without chemotherapy privileges may write for chemotherapy only if they have been granted privileges by the medical staff to do so as related to their specialty including but not limited to:
   i. Ectopic pregnancy
   ii. Rheumatoid arthritis
   iii. Systemic lupus erythematosus
   iv. Certain dermatologic conditions
   v. Certain ophthalmic procedures
   vi. Other auto-immune conditions as identified in the literature
   vii. Androgen deprivation therapy for prostate cancer

b. All orders must be written on a standard ~~pre-printed~~ **TCHD** Chemotherapy Order Form and subject to all other requirements stated above.
   i. Use of standard pre-printed form is not required only if:
      1) Oral agent is prescribed for a non-~~malignant~~ **oncologic** condition and may be ordered via computerized provider order entry (CPOE).
      2) Androgen deprivation therapy is prescribed by an urologist or oncologist for prostate cancer.
      3) **Intramuscular (**IM**)** methotrexate is ordered for ectopic pregnancy via CPOE
   ii. Outpatient oral chemotherapy may be continued in-house by an attending physician via CPOE. Pharmacist shall verify that patient is currently on oral chemotherapy regimen.

c. Non-systemic chemotherapy such **as** intrathecal~~ly~~, intravesical ~~ly~~ or directly into an organ (i.e. chemoembolization) may be ordered and administered by a qualified physician in other areas of the hospital (interventional radiology, operating room). Use of standard ~~pre-printed~~ **TCHD** Chemotherapy Order Form is not required.

C. **CHEMOTHERAPY PROCESSING PROCEDURE:**

~~A. The pharmacist will confirm that the order has been prescribed according to the criteria above. The pharmacist shall contact the physician to request that any order not meeting these criteria be changed.~~
~~All addendums or changes to original orders must be documented on a Chemotherapy Order Form. Changes to the order made by the physician (as above) must be double checked by a second pharmacist.~~
~~If there is a discrepancy in the medication order, nursing will be notified of the problem and the possible delay in the delivery of the medication.~~
~~**A chemotherapy worksheet will be prepared for each compounded drug in the prescribed regimen. The following information shall be documented:**~~
~~**Patient name and second identifier (i.e. DOB and/or medical record number)**~~
~~**Height, weight, body surface area**~~
~~**Diagnosis, allergies, doctor's name and regimen name**~~
~~**Full generic medication name, dose/m^2, dose/kg, or AUC, route, frequency and any special medication instructions that are different than institutional standards**~~
~~**Appropriate cycle number and day along with corresponding date of treatment**~~
~~**Cumulative dose for medications with dose ceilings**~~
~~**Two independent checks by pharmacists will be performed at the beginning of each cycle and documented on the chemotherapy worksheet. This will include:**~~Once the prescribing criteria have been met, the pharmacist is responsible for verifying the accuracy of the order by:
~~**T**~~Confirming the two (2) patient identifiers
~~**D**~~Reviewing the diagnosis and prescribed regimen (drug name, dose, route and frequency)
Calculating ~~**Calculation**~~ the patients'~~**of**~~ BSA, unit conversions and patient-specific dose
Reviewing ~~**Correct d**~~diluents, drug volumes, rate of administration, drug concentration requirements, drug stability, administration times, infusion guidelines and supportive care medications
~~**A**~~Verifying appropriate labs have been ordered and are within acceptable ranges for the ordered chemotherapy medications or if ~~**dosage adjustments**~~ treatment modifications are ~~**required**~~indicated
~~**C**~~Confirming correct time interval has elapsed between treatments

~~**D**~~Reviewing drug allergies and sensitivities along with adverse drug effect histories
~~**Evaluation of c**~~Current medication profile should be evaluated for potential drug interactions with antineoplastic therapy
~~Upon completion of the verification process, the pharmacist will prepare a chemotherapy work sheet for use in preparing the prescribed regimen. One worksheet must be filled out for each patient. The following information should be documented:~~
~~Patient name second identifier (i.e. DOB and/or medical record number)~~
~~Height, weight, body surface area~~
~~Diagnosis, allergies, doctor's name and regimen name~~
~~Full generic medication name, dose/m^2 or AUC, route, frequency and any special medication instructions that are different then institutional standards~~
~~Appropriate cycle number and day along with corresponding date of treatment~~
~~Cumulative dose for medications with dose ceilings~~
~~The order shall be entered into the electronic health record (EHR) under the patient's medication profile.~~
~~A second pharmacist must verify the accuracy of the regimen, chemotherapy worksheet and corresponding entries in medication profile and initial the work sheet to signify approval.~~

~~Changes in subsequent doses should be noted on the chemotherapy worksheet and must be double checked and initialed by a second pharmacist.~~
~~Explanation of reason for changing subsequent doses shall also be documented.~~
~~On the day of treatment, the~~ **processing** ~~verifying pharmacist must~~ **initial that** ~~check the following~~ **has been verified**~~:~~
~~**The cycle has been checked and signed off by two (2) pharmacists.**~~
~~Dose changes based on weight:~~

1. **Pharmacist verification for new chemotherapy regimens:**
   a. **Two independent pharmacist checks will be performed to ensure the order follows the Chemotherapy Prescribing Procedure prior to the initiation of a new chemotherapy regimen.**

~~Cytotoxic chemotherapy: The dose is within 5% of treatment plan dose based on the current weight.~~
~~Monoclonal antibodiess: The dose is within 10% of treatment plan dose based on the current weight.~~
~~Any questions regarding weight that could affect the treatment regimen will be brought to the physician's attention.~~
~~Chemotherapy orders have not changed between the original regimen verification and the actual day of treatment and all computerized order entries are correct.~~
~~Changes~~ **to dose along with reasons for dose modifications** ~~in subsequent doses should be noted on the chemotherapy worksheet and must be double checked and initialed by a second pharmacist.~~
~~Explanation of reason for changing subsequent doses shall also be documented.~~

~~**Required**Appropriate labs are drawn within the appropriate time interval and are regimen specific.~~
~~Labs will be evidence based **per** when national guidelines (e.g. American Society of Clinical Oncology [ASCO]/ National Comprehensive Cancer Network [NCCN]) **or** exist or determined by practitioner~~
~~a. Guidelines for timing of labs:~~
~~1) In chemotherapy naïve patients (no prior chemo) lab results should be no older than seven (7) days.~~
~~2) For patients currently receiving chemo with the following frequencies:~~
~~a) Every seven (7) days – lab results should be within two (2) calendar days~~
~~b) Every fourteen (14 days) and beyond – lab results can be within three (3) calendar days (i.e. 72 hours)~~
~~3) Daily (consecutive days of chemo) – labs should be drawn on day one (1).~~
~~4) Older labs may be accepted at the pharmacists~~**ss''** ~~discretion.~~
~~ii. Any abnormal lab values that could affect the treatment regimen will be brought to the physician's attention.~~

2. ~~In the absence of treatment parameters, the lab values of ANC ≤ 1500 cells/µL, platelets ≤ 100,000/uL total bilirubin ≥ 1.4 mg/dL, CrCl <60 mg/dL (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved with physician before preparation of dose.~~ **Two pharmacists working independently verifies the following prior to each dose dispensation:**
   a. **Two patient identifiers**
   b. **Drug name**
   c. **Drug dose**
   d. **Route of administration**
   e. **The calculation for dosing, including the variables used in this calculation**
   f. **Treatment cycle and day of cycle**

g. **The correct time has elapsed between treatments.**
h. **Weight and labs are within range and dose adjustments are confirmed with oncologist.**
i. **Allergy, drug sensitivity, adverse drug effect histories and current medication profile should be evaluated for potential drug interactions with planned chemotherapy treatment.**
j. **Concentration of drug in IV solution is within acceptable concentration range.**
k. **Drug and solution are compatible.**
l. **Correct bag, tubing and filter have been selected.**
m. **Chemotherapy orders have not changed after the initial two pharmacist new chemotherapy regimen check performed prior to cycle one.**
   i. **If regimen has been modified or changed, two pharmacists must recheck that the order is prescribed according to policy.**
n. **All electronic order entries match paper order sets.**

3. **All checks will be documented electronically or on a chemotherapy worksheet.**

~~b. Confirm the cycle has been checked and signed off by two (2) pharmacists.~~
~~c. The **verifying** pharmacist that performs steps a through e above will initial the chemotherapy worksheet signifying that this part of verification has been done.~~
~~i. A second pharmacist will verify **same** steps a through f above and initial chemotherapy worksheet.~~

~~2.~~**4.** The verification process must be followed completely before any dose can be prepared.
   a. Exceptions
      For TCHD OIC, the second pharmacist verification ~~as outlined above~~ can be omitted.

D. **CHEMOTHERAPY PREPARATION AND DISPENSING ~~PROCEDURE~~:**

1. **Chemotherapy is prepared by a licensed pharmacy technician or pharmacist.**
2. **If an oral chemotherapy or other hazardous drug is to be physically manipulated or repackaged, the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.**
   a. **The hood must be cleaned according to policy and procedure prior to sterile compounding.**
3. **All intravenous hazardous chemotherapy will be prepared using a Closed System Transfer Device (CSTD), if compatible, in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.**
4. **All parenteral hazardous chemotherapy medications will be spiked and primed in the chemo hood if dispensed as IV piggyback.**
5. **The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be checked by the pharmacist before injecting into IV solution**
   a. **The syringe pullback method is not to be used for chemotherapy final volumes.**

~~The technician responsible for preparing the doses must gather the order, chemotherapy worksheet, patient-specific labels, medication, and associated supplies.~~
~~The technician is responsible for recording the following for preparation records:~~
~~Patient name and one other identifier~~
~~Time and date the product was prepared~~
~~Medication, concentration and volume used~~
~~The lot number/expiration date from the medication vial and intravenous (IV) diluent bag.~~
~~The technician must initial the chemotherapy worksheet, product label and preparation records and perform all calculations associated with the compounding process.~~
~~If an oral chemotherapy drug is to be physically manipulated or repackaged, the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.~~

~~All intravenous chemotherapy will be prepared using a Closed System Transfer Device (CTSD) whenever possible in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.~~
~~All parenteral chemotherapy medications will be spiked and primed in the chemo hood if dispensed as IV piggyback.~~
~~The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be pulled back to indicated the measured volume or shown to the pharmacist before injecting into IV solution.~~
~~The pharmacist, working independently must verify the following:~~
~~The current cycle and verification boxes have been signed off on the chemotherapy work sheet.~~
~~The patient specific labels match the chemotherapy worksheet.~~
~~The correct medication has been chosen~~
~~The drug was reconstituted correctly using the correct volume and diluent~~Final container integrity and correct type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.
~~The volume of drug used was accurately measured for the prescribed dose~~
~~The label is correct and includes at least:~~
~~Patient's full name and second patient identifier (i.e. DOB or medical record number)~~
~~Full generic drug name~~
~~Drug administration route~~
~~Total dose to be given~~
~~Total volume required to administer dosage~~
~~Date of administration~~
~~Date and time of preparation~~
~~Date and time of expiration if not for immediate use~~
~~Special handling instructions and caution statements (i.e. intrathecal use only)~~
~~Final concentration of product on syringe labels (i.e. doxorubicin 50mg/ 25mL)~~
~~All minibag or large volume parenterals include volume of each component as well as a total volume~~
~~Rate of administration~~
~~a. Final container integrity and correct type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.~~
~~b. All intrathecal doses~~

6. **All intrathecal doses:**
   - ~~c.~~**a.** ~~Must~~ **Shall** not be prepared during preparation of any other agents
   - ~~d.~~**b.** **Are l**~~L~~abeled with an identifiable intrathecal medication label
   - ~~e.~~**c.** Must be placed in a separate transport bag
   - ~~f.~~**d.** **Shall b**~~B~~e delivered only with other medications intended for administration intrathecally

~~2.~~**7.** Maximum syringe size dispensed should be 35 mL
   a. Any IV push dose in **a** syringe should be less than three quarters full to minimize the risk of chemo spill.

8. An overfill volume of 0.05 ml will be added to all subcutaneous doses
9. **Two pharmacists, working independently must verify the following:**
   - **a. The drug vial(s)**
   - **b. Concentration**
   - **c. Drug volume or weight**
   - **d. Diluent type and volume, when reconstituted**
   - **e. Administration fluid type, volume and tubing**
   - **f. Final appearance and integrity of drug and container**
   - **g. Type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.**
   - **h. Expiration date and times**
   - ~~b.~~**i. Exception: For TCHD OIC, the second pharmacist verification can be omitted.**

10. Upon completing the chemotherapy preparation process, the final product **shall be labeled immediately upon preparation**

a. Labels include the following elements, at a minimum:

i. Patient's full name and second patient identifier (i.e. date of birth or medical record number)
ii. Full generic drug name
iii. Drug dose
iv. Drug administration route
v. Rate of administration
vi. Total volume required to administer the drug
vii. Date the medication is to be administered
viii. Expiration or beyond use date and time
ix. Sequencing of drug administration, when applicable, and total number of products and individual products sequence within that total grouping when medication is provided in divided doses
x. Special handling instructions and caution statements (i.e. intrathecal use only)
xi. Final concentration of product on syringe labels (i.e. doxorubicin 50mg/ 25mL)
xii. All minibag or large volume parenterals include volume of each component as well as a total volume

~~shall be affixed with patient specific labels~~

~~3.~~**11.** All hazardous chemotherapeutic agents regardless of route and indication shall be dispensed from the pharmacy with an auxiliary Chemotherapy Warning label

~~4.~~**12.** Any IV line that has been primed with active drug will be dispensed from the pharmacy with appropriate auxiliary label

~~5. The pharmacist must sign their initials on the chemotherapy work sheet, patient specific label and preparation records to signify product verification.~~

~~6. The pharmacist must ensure the technician has initialed all aforementioned places as well.~~

~~7.~~**13.** All chemotherapy doses are placed in a sealable chemotherapy bag

~~a. Delivery~~

~~8.~~**14.** ~~Must~~**Chemotherapy must** be put into a chemotherapy cooler containing a spill kit for transportation out of pharmacy.

~~9. Chemotherapy leaving the hospital must be double bagged.~~

~~10.~~**15.** Chemotherapy will only be delivered to designated oncology floors.

E. **FORM(S):**

1. Chemotherapy Orders 8711-3222 Form - Sample

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

1. Patient Care Services Policy: Identification, Patient
2. Patient Care Services Procedure: Hazardous Drugs

G. **REFERENCE(S):**

1. Neuss, M. N; et al. (201~~63~~) **2016 Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards, Including Standards for Pediatric Oncology**~~Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards Including Standards for the Safe Administration and Management of Oral Chemotherapy~~. *Journal of Oncology Practice.*
2. **Goldspiel B, Hoffman JM, Griffith NL, et al.** ~~American Society of Health-System Pharmacists.~~ ASHP Guidelines o~~O~~n Preventing Medication Errors With ~~antineoplastic agents~~**Chemotherapy and Biotherapy**. Am J Health-Syst Pharm. 201~~502~~; ~~59:1648–68~~**72:e6-35**.

Chemotherapy Orders 8711-3222 Form - Sample

☐ **Inpatient** ☐ **Outpatient** **Cycle#**_______________

DIAGNOSIS/REGIMEN/MNEMONIC:_______________

ALLERGIES:_______________

CURRENT Height ______(in)________ (cm) Weight ________(kg)_________ (lbs) BSA _______ (M^2) CrCl_______

Cumulative Dose (If Applicable)_______________

CHEMOTHERAPY AGENTS

Note: Diluent/Volume/and Rate of Administration per Standard of Practice unless otherwise stated in Chemo Instructions

Start Chemo Date:	Agent	Mg/M^2 dose	Mg dose	Route of Administration	Frequency (continuous, every _ hrs, day 1,3,5, etc.)	Duration (X_days, X_doses)
				☐ Infusion ☐ **Sub Q** ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ **Sub Q** ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ **Sub Q** ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ **Sub Q** ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		
				☐ Infusion ☐ **Sub Q** ☐ IVPB ☐ PO ☐Intrathecal ☐ IVP ☐		

Chemo Instructions or reasons for dose modifications: _______________

____

____

Pre-medications: _______________

____

Hydration: _______________

Anti-emetics: _______________

Lab/Diagnostic Test(s): _______________

☐ Notify MD with Lab/Diagnostic test(s) prior to chemo administration

☐ Access Mediport ☐ Place PICC Line

☐ Heparinize Mediport PRN ☐ Infuse via Periph IV

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
8711-4010

CHEMOTHERAPY ORDERS

Page 1 of 1

8711-3222 Revised (04/15) PHYSICIAN'S ORDERS Board Approved 04/15

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/02 **SUBJECT: Code Blue Response Plan**

REVISION DATE~~(S)~~: 11/02, 03/03, 05/05, 05/06, 11/07, 01/08, 01/09, 02/10, 05/11, 03/16, 05/20

Patient Care Services Content Expert Approval:	~~05/18~~05/21	
Clinical Policies & Procedures Committee Approval:	~~08/18~~11/21	
Nursinge Leadership~~Executive Committee~~ Approval:	~~09/18~~11/21	
Department of Emergency Medicine Approval:	~~11/19~~04/22	
Critical Care Committee~~Division of Pulmonary~~ Approval:		~~03/20~~08/22
Pharmacy & Therapeutics Committee Approval:	n/a	
Medical Executive Committee Approval:	~~04/20~~06/23	
Administration Approval:	~~05/20~~08/23	
Professional Affairs Committee Approval:	n/a	
Board of Directors Approval:	05/20	

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary emergency on adults or children age fourteen (14) or older within the hospital and outside of the facility on hospital property.

B. **DEFINITION(S):**

1. Justice Involved Individual: Any individual who is under lawful physical arrest/ in the custody of a Law Enforcement Officer and brought to Tri-City Healthcare District (TCHD) to receive medical care, evaluation, treatment, or admission.

C. **POLICY:**

1. A Code Blue shall be called on any apneic and/or pulseless adult or child age fourteen (14) or older.
2. Any person may initiate a Code Blue by dialing '66' on the telephone. The Operator shall announce "Code Blue" and the location over the public address (PA) system three (3) times, twice.
   a. For a Code Blue in a non-patient care area where crash carts are not readily available (for example, the Business Administration Building, Human Resources, Security Buildings and parking areas), staff shall also dial 911 on the telephone to initiate local Emergency Medical Response (EMR) team.

D. **RESPONSE PLAN ON MAIN CAMPUS:**

1. Remove the patient from any wet areas or metallic objects to prevent burns and inappropriate transmission of current.
   a. Justice Involved Individual: ensure the patient's metal shackles are removed prior to defibrillation or emergent cardioversion.
2. Initial response in non-cardiac monitored areas:
   a. Staff shall initiate Basic Life Support (BLS) measures until Code Blue Response Team arrives.
3. Initial response in cardiac monitored areas:

a. Staff shall initiate BLS and Advanced Cardiac Life Support (ACLS) measures and initiate the Code Blue and Emergency Care Standardized Procedure until the Code Blue Response Team arrives.

4. Code Blue response team:
   a. The following staff shall respond to the Code Blue (see Shared Mental Model for suggested positions around the patient):
      i. Two (2) Intensive Care Unit (ICU) Code Blue Registered Nurses (RN):
         1) Bring Code Blue Cart (contains defibrillator/pacemaker and resuscitation bag/mask), emergency intubation medications, and intraosseous insertion kit to the scene.
            a) If the code blue occurs in the Cardiac Wellness Center, the responding Code Blue Team members are responsible for bringing the emergency intubation drugs and intraosseous insertion kit only.
         2) Initiate and implement the Standardized Procedure for Code Blue and Emergency Care until the physician arrives.
         3) Remain with patient until released by physician or patient is transferred to receiving unit.
            a) Inpatients shall be transferred to the ICU or appropriate level of care based on physician order.
            b) Non-inpatients shall be transferred to the Emergency Department (ED)
         4) Complete ~~the Emergency Event form~~ **documentation of the event** in the patient's electronic health record (EHR).
      ii. Intensivist:
         1) Responds ~~when~~ **24 hours, 7 days per week**~~available~~ and shall be responsible for **leading resuscitative efforts and** post-resuscitative care
         ~~2) If patient is already in ICU, Intensivist shall respond when present and shall be responsible for leading resuscitative efforts and assuming post-resuscitative care~~
      iii. Emergency Department (ED) Physician:
         1) ~~Respond and s~~**S**hall be responsible for **supporting the Intensivist (as needed) during the resuscitation**~~leading resuscitative efforts~~
      iv. Hospitalist:
         1) Responds and shall be responsible for coordinating post-resuscitative care
      v. Primary RN:
         1) Remain in room to assure responders have current patient information.
         2) Access patient's record and assures responders have information requested (i.e., labs, x-rays, reports).
         3) Document in the EHR:
            a) Pre-code assessment findings
            b) Interventions implemented prior to Code Blue team arrival
         4) Delegate notification of the family member/significant other and physician regarding change in patient condition.
         5) Provide communication to receiving nurse if family member/significant other and physician have been notified
      vi. Two (2) Respiratory Care Practitioners:
         1) Ventilate patient
         ~~1)~~**2) Assist with securing a patent airway**
         ~~2)~~**3)** Obtain arterial blood gases as ordered
         ~~3)~~**4)** Document interventions performed ~~on the Emergency Event record~~**in the patient's EHR.**
      vii. Electrocardiogram (ECG) Technician:

1) Bring ECG machine

viii. ~~Lift Team~~**All Patient Mobility Technicians (PMTs) and PMT Dispatcher**:
1) Bring gurney and backboard to **events in non-inpatient** areas
2) Assist with cardiopulmonary resuscitation (CPR)
3) Transport patient to receiving unit

ix. ~~Assistant Nurse Manager(ANM)/ Relief~~ Charge Nurse or Designee:
1) Complete Cardiopulmonary Arrest Record and provides completed form to ICU Code Blue RN
2) Ensure, post code the medication tray inside of the crash cart is re-locked with a secure tie**s** (located in the crash cart) for containment at end of code
3) Ensure, post Code, the opened crash cart is locked with the **secure tie**~~plastic key lock~~ externally, is placed in a secured area, and the Sterile Processing Department (SPD) is notified to pick up the used cart

x. Administrative Supervisor:
1) Ensure only required personnel are positioned around patient and nonessential personnel are released to their regular duties.
2) Facilitate communication to patient's family during the code

xi. Unit Secretary:
1) Assure patient's chart is available as appropriate and places call to primary physician as directed
2) Other duties as directed by Code Blue Team

xii. Security Personnel:
1) Maintain scene safety and keep area clear of congestion

xiii. Sterile Processing Department:
1) Send an adult crash Cart and two infusion pumps to the area involved
2) Retrieve used crash cart and intubation tray post code

b. For a Code Blue in non-patient care areas where crash carts are not readily available:
i. In addition to the above responders, the following will respond:
1) ED Emergency Medical Technicians (EMTs)
a) Bring defibrillator, airway bag, resuscitation bag/mask, gurney and backboard to the scene

ii. TCHD staff will update the EMR team upon their arrival

E. RESPONSE PLAN AT AFFILIATED CENTERS:

1. Examples including but not limited to:
a. Home Care
b. Hospice
c. Outpatient Behavioral Health Services
d. Outpatient Rehabilitation Service Center
e. Outpatient Nuclear Medicine
f. Outpatient Imaging
g. Open MRI
h. Vista Palomar Park Clinic
i. Wound Care Center
j. Tri-City Wellness Center: Cardiac Rehab & Outpatient Rehab
k. Outpatient Infusion Center
2. The staff **in** ~~of~~ the above mentioned areas are to initiate BLS measures and call 911 to facilitate management and transport of the patient to the ED.
3. The staff in Home Care, Partial Hospitalization, and Outpatient Rehabilitation Services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

F. RELATED DOCUMENT(S):

1. Patient Care Services Policy: Justice Involved Patients

2. Patient Care Services Standardized Procedure: Code Blue and Emergency Care
3. Shared Mental Model: Positions Around the Patient

F. **REFERENCE(S):**

1. American Heart Association (~~2015~~**2020**). BLS for healthcare providers: *Professional Student Manual.*
2. American Heart Association (AHA) (~~2015~~**2020**). ~~Highlights of 2010 AHA guidelines for CPR~~
3. American Heart Association (AHA) (~~2015~~**2020**). Handbook of emergency cardiovascular care for healthcare providers.
4. Pediatric advanced life support (~~2015~~**2020**). American Heart Association (AHA).

Code Blue: Shared Mental Model

Plan

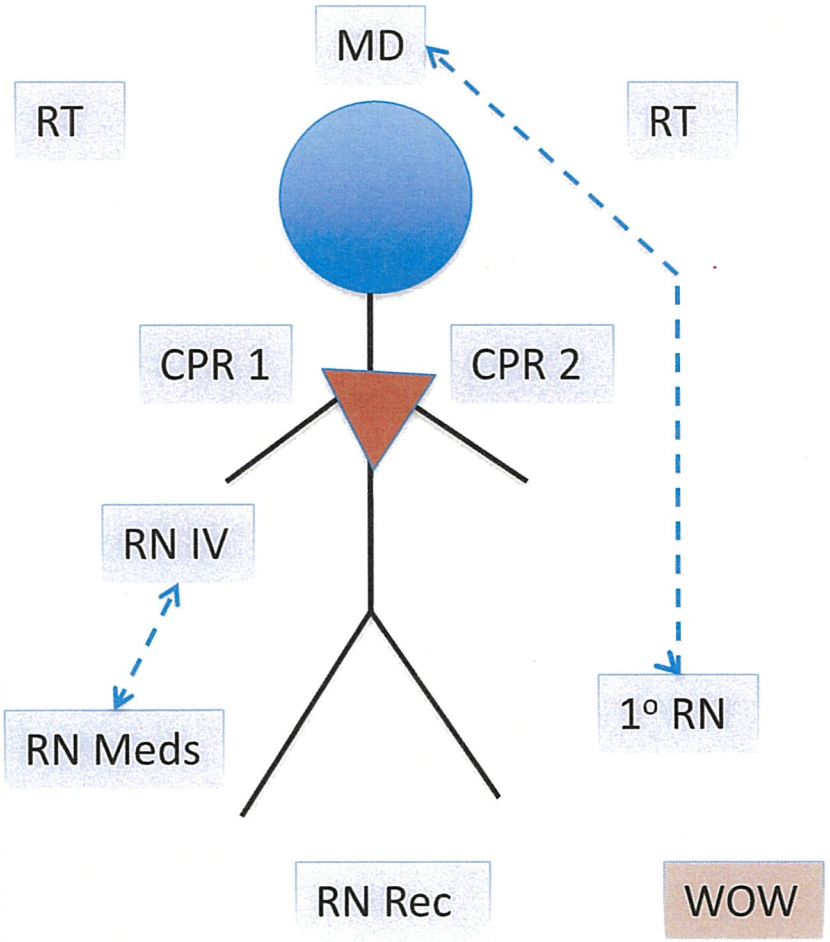
Brief: WWW.PS Defibrillate
- Who
- What
- Where
- Problems/Limitations
- Safety/Speaking
- Defibrillate

Closed-loop communication
No talking:
-during SBAR
-during pulse checks
-speak up when safety issues arise

Protect yourself
-wear gloves, glasses, etc.
Protect the team
-sharps, family, etc.

Debrief (3 min max)
-what went well, bad, etc.

Suggested Positions around patient



Responsibilities

Floor Staff – Apply Zoll/ AED, start compressions

1º RN – Provide background, pertinent info

RN IV – secure/start IV

RN Med – Open crash cart, get epi, prep meds for RN IV

RN Rec – Document on CPA Record; update team every few minutes (CN, ANM, etc)

CPR 1&2 – CPR, alternate Q 2 min (PMT, EMT, ACT, etc)

AS – Crowd control, facilitate transfer to ICU

WWW.PS Defibrillate

Who, What, Where, Problems, Speak up (or be Quiet!), Defibrillate

Who are you?	Introduced by Name and Title
What are you doing?	Assignments/Roles defined
Where is equipment?	Equipment and Meds checked
Problems/Limitations	Identified and Discussed
Safety/Speaking	Reviewed
Defibrillate!	Check for V Fib now

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) EXCHANGE; CONTINUOUS CYCLER PERITONEAL DIALYSIS (CCPD) EXCHANGE**
Purpose:	To outline nursing responsibilities in, trouble shooting and disconnecting a patient that has a Liberty ® Cycler (CCPD), and responsibilities in CAPD exchanges, trouble shooting and disconnecting a patient that has a Fresenius Stay Safe CAPD exChange exchange
Supportive Data:	To maintain aseptic technique when disconnecting patients from a CAPD or CCPD device in addition to maintaining the CAPD and CCPD treatment for the patient when San Diego Dialysis, Inc nurses are not available within the facility.
Equipment:	Mask, Gloves, Del Clamps™, IV Pole (CAPD), Spring Scale (CAPD), Chux Pad, Blue plastic hemostats

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) has contracted San Diego Dialysis Services, Inc. to administer peritoneal dialysis including set up and support for inpatients receiving peritoneal dialysis as needed.
2. The responsibility of the San Diego Dialysis Services, Inc., per their contract, will be to:
   a. Prepare, connect, monitor and disconnect patients requiring peritoneal dialysis.
   b. Administer medications as ordered by privileged TCHD physicians during continuous ambulatory peritoneal dialysis (CAPD) and automated peritoneal dialysis (APD) treatments.
3. The CAPD and continuous cycler peritoneal dialysis (CCPD) trained nurses will be responsible for trouble shooting alarms on the Liberty cycler.
4. CAPD or CCPD trained nurses may also be required to disconnect peritoneal dialysis patients from the Liberty Cycler® Stay Safe ® when the San Diego Dialysis Services, Inc.'s dialysis nurses are unable to disconnect patients due to immediate procedures or time constraints related to in house hemodialysis patients.
5. Emergency equipment shall be readily available at patient's bedside for emergency disconnection for both CAPD and CCPD patients includes:
   a. 2 Masks (nurse and patient)
   b. Gloves
   c. Chux
   d. 1 Stay Safe® Cap
   e. 1 Stay Safe® Organizer
   f. Blue plastic hemostats (if patient's catheter does not have a clamp)

B. **PROCEDURE:**

1. CCPD for the Liberty Cycler®:
   a. Trouble-Shooting:
      i. Refer to the Peritoneal Dialysis Manual to trouble shoot any alarms on Liberty® Cycler.
      ii. If unable to trouble shoot alarms on the APD for the Liberty Cycler®: by using the Peritoneal Dialysis Manual, contact the on call Dialysis nurse at 1-855-726-9720
   b. Disconnecting with the Liberty Cycler with Stay Safe® Patient Connectors:
      i. Place a new Stay Safe® Cap in the notch on the Organizer.
      ii. Turn the blue end of the Patient Connector clockwise until it stops.
      iii. Push in the blue end of the Patient connector until it stops.
      iv. Close the clamp on the Extension Set.

Department Review	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Pharmacy and Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/06, 06/12, 12/17, **05/23**	07/12, 02/18, **05/23**	08/12, 03/18, **06/23**	n/a	08/12, 03/18, **07/23**	**08/23**	09/12, 04/18, **n/a**	09/12, 04/18

v. Insert the Patient Connector into the Organizer.
vi. Remove the protective cover from the new Stay Safe® Cap.
vii. Unscrew the Extension Set from the Patient Connector.
viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
ix. Connect the protective cover on the used Patient Connector.
x. Document the CCPD output, color, and clarity of fluid using the I&O form in Cerner. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

C. **PROCEDURE:**

1. CAPD Stay Safe single exchange
   a. The following supplies are needed to perform the Fresenius Stay Safe CAPD Exchange Procedure:
      i. Bag of Stay Safe Delflex solution with appropriate dextrose percent (%), as ordered by the physician
      ii. Stay Safe® Organizer
      iii. Stay Safe® Cap(s)
      iv. Masks for everyone in the room
      v. Personal protective equipment (PPE) for staff, patient/caregiver as instructed by dialysis nurse
      vi. Liquid antimicrobial soap and/or alcohol based hand sanitizer
      vii. Intravenous (IV) pole
      viii. Spring scale (optional)
      ix. Organizer holder (optional)
   b. Apply masks to all persons in the room; staff applies remaining PPE except gloves.
   c. Wash hands with liquid antimicrobial soap and water per Infection Control Procedure: Hand Hygiene – IC 8.
   d. Apply non-sterile gloves (staff).
      i. Place a new Stay Safe® Cap in the notch on the Organizer.
      ii. Turn the blue end of the Patient Connector clockwise until it stops.
      iii. Push in the blue end of the Patient connector until it stops.
      iv. Close the clamp on the Extension Set.
      v. Insert the Patient Connector into the Organizer.
      vi. Remove the protective cover from the new Stay Safe® Cap.
      vii. Unscrew the Extension Set from the Patient Connector.
      viii. Connect the Extension Set to the new Stay Safe® Cap and remove from Organizer.
      ix. Connect the protective cover on used Patient Connector.
      x. Document the CCPD output, color, and clarity of fluid in the medical record. All CCPD patients must have the CCPD output recorded after every completed CCPD exchange.
      xi. If patient is to be discharged after CCPD is completed, an assessment shall be completed by the San Diego Dialysis Services, Inc.'s nurse prior to discharge.

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

1. Infection Control Procedure: Hand Hygiene - IC 8

E. **REFERENCE(S):**

1. Fresenius Liberty Cycler Termination of Treatment Procedure FMS-CS-ii-I-530-110C4 18-DEC-2013
2. Fresenius Stay Safe CAPD Exchange Procedure FMS-IS-II-I-530-082C 18 DEC-2013

3. Fresenius Peritoneal Dialysis Procedure Manual-Clinical Services 1-200-0001-SD

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**FEMOSTOP COMPRESSION DEVICE**
Purpose:	FemoStop Femoral Compression System is indicated for use in the compression of the femoral artery or vein after vessel cannulation and in ultrasound-guided compression repair of a femoral artery pseudoaneurysm.
Supportive Data	The benefits of this procedure are consistent placement; having time-controlled pressure, and decreased groin site vascular complications. Elsevier Skills: Arterial and Venous Sheath Removal Procedure
Equipment:	Femostop or compression dome arch with attached manometer. (For one time use only. Do not reuse) Belt of FemoStop® Suture removal kit Patent Intravenous (IV) access site Doppler Chux or drape for padding Gloves 1 box of ten 4x4s or 6 packages of 4x4s Tape (preferable Elastoplast or similar product) Clear occlusive dressing such as a tegaderm

A. **DO NOT USE FEMOSTOP COMPRESSION DEVICE IF THE PATIENT HAS THE FOLLOWING CONTRAINDICATIONS:**

1. Severe peripheral vascular disease due to the risk of arterial thrombosis
2. Critical limb ischemia
3. Overlying skin necrosis and/or infection
4. Arterial injuries above or near the inguinal ligament
5. The inability to adequately compress due to i.e. coexisting large hematoma, excessive pain or discomfort (despite anesthetics/analgesics)
6. Patient not suitable for compression of the femoral artery due to leg edema, femoral nerve compression or arterial obstruction
7. Femoral artery graft or vein graft due to the risk of damage
8. Ultrasound-guided compression repair of infected femoral pseudoaneurysms

B. **POLICY:**

1. Review Online Skills Arterial and Venous Sheath Removal procedure for additional information on removing venous and arterial sheaths.
2. If "HHH" is shown on the display, too much pressure has been applied. Open the control knob and decrease the pressure immediately.
3. Ensure that the pinch clamp is open when increasing or decreasing the pressure.
4. Maintain initial hemostasis pressure for about 1- 3 minutes and do not leave artery completely blocked for more than 3 minutes to prevent limb ischemia.
5. Check pedal pulse periodically to confirm whether or not flow remains in the vessels.
6. Avoid releasing pressure suddenly to reduce any risk of flushing thrombotic material into the artery.
   a. Release of thrombotic material may result in embolization which could lead to patient injury.
7. To minimize the risk for arterial/venous fistula formation, venous hemostasis should be achieved prior to removal of the arterial sheath.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
01/00, 07/03, 04/04, 01/06, 06/08, 02/09, 06/11;10/15, 05/19, **04/23**	11/11, 08/15, 11/15, 04/20, **05/23**	11/11, 12/15, 05/20 **06/23**	n/a	n/a	01/12, 01/16, 05/20, **07/23**	06/20, **08/23**	02/12, 02/16, n/a	02/12, 02/16, 06/20

8. Use of FemoStop Femoral Compression System is not intended to replace careful monitoring of the patient's puncture site. The patient should not be left completely unattended during the time of compression.

C. **PROCEDURE:**

1. Explain procedure to patient.
2. Ensure patient has patent IV access.
3. Examine puncture sites for preexisting hematoma prior to placement of the device.
   a. If a preexisting hematoma is present, notify the physician for further orders.
4. Perform hand hygiene and don gloves.
   a. If site is palpated, don sterile gloves.
5. Assess pre-sheath removal blood pressure, heart rate, and cardiac rhythm. Check and mark location of pulses.
   a. If unable to palpate previously assessed palpable pulses, confirm pulses with a Doppler and notify physician.
6. Activate the pump ~~by~~:
   a. Loosen (-open) the control knob ensuring the control knob clears the red battery contact release tab.
      i. Failure to ensure the control knob clears the red battery contact release results in device failure. If this occurs, discard the device and obtain a new one.
   b. Pull the red battery contact release in the direction of the arrow. When --- (three dashes) are shown on the display followed by the number zero, the pump is activated. (If the three dashes do not appear discard the FemoStop and get a new one).
      i. If the following error code(s) appears on display (E01, E03, etc.) replace FemoStop.
   c. The pump software will automatically shut down 72 hours after activation and will show an error code if any attempts to reactivate.
   d. If an error code shows or the display goes blank before or during use, replace the device with a new unit.
   e. Ensure that the control knob on the pump is closed when increasing the pressure and open when decreasing the pressure.
   f. Ensure that the pinch clamp is open when increasing or decreasing the pressure.
7. Application of the belt:
   a. Drape patient and position ~~and . place~~ belt under and around the patient's hips, so that it is pulled up equally on both sides and is directly in line with the puncture site(s).
      i. Check that the belt has not become twisted or folded under the patient.
   b. Remove compression arch from sterile package.
      i. Remove the protective lid from the sterile surface of the dome. Be careful to maintain sterility of the dome.
      ii. Do not contaminate sterile surface.
   c. Palpate the entrance site of the sheath(s) at the femoral artery/vein and position center of pressure dome 1 to 2 cm superior (above) and medial to the arterial insertion site (where the arterial/venous sheath enters the skin).
      i. Thread the belt through the locks at either end of the arch by fully compressing the levers.
      ii. Adjust the belt to a snug but comfortable fit around the patient. The arch should lie level and squarely across the groin area.
8. Follow the procedures Online Skills Arterial and Venous Sheath Removal Procedure: Using Manual or Mechanical Compression without a Noninvasive Hemostasis Pad and the instructions below:
   a. Removal of venous sheath.
   b. Removal of arterial sheath.

D. **PROCEDURE: LOW FEMOSTOP DOME PRESSURE**

1. Inappropriate inflation compression times and/or immobilization may increase risk of thrombosis or embolization, caution should be used when using low FemoStop dome pressure greater than 3 hours.
2. After hemostasis is maintained, low FemoStop pressure (maintenance pressure) may be applied by inflating the dome to 30 mmHg or less when appropriate for the patient's condition. Examples include but are not limited to:
   a. Anticoagulant level
   b. Interventional procedure performed
   c. Physician order
   d. Sheath French size used
   e. Loss of hemostasis
   f. Oozing secondary to anticoagulant or antiplatelet dose
   g. Sustain hemostasis for patients unable to follow instructions
3. The patient's baseline pedal pulse must be palpable.
4. Low FemoStop pressure is equivalent to the weight of approximately a 10-pound sand bag.
   a. Apply sand bag only per physician's order.
5. Low FemoStop pressure must be decreased and the dome removed from contact with patient's skin every 3 hours to allow capillary refill when long compression times are required and assess skin integrity if a dressing has not been applied.
6. Assess pulse and temperature of skin with every interruption of Low FemoStop pressure.
7. Assess patient's vital signs per physician's orders.
8. Assess patient's cardiac rhythm per unit specific policy.

E. **PROCEDURE: REMOVAL OF VENOUS SHEATH without an ARTERIAL SHEATH:**

1. Access the following:
   a. Puncture site area for any pre-existing hematomas
   b. Blood pressure to determine proper initial inflation pressure
   c. Pedal pulse
   d. Palpate entrance site of sheath
2. Follow the instructions for applying the belt and FemoStop
   a. The belt may be threaded through the end of the arch before or after applying the belt.
3. Remove the sutures using the suture removal kit, if present.
4. Withdraw introducer (sheath) hub(s) about 2cm or just enough to clear the rim of the dome.
   a. Verify stopcock is parallel with the pressure tubing prior to slightly withdrawing the sheath hub.
5. Ensure the control knob of the pump is closed prior to inflating the dome.
6. Inflate dome to 20 - 30 mmHg pressure and remove venous sheath. Add additional pressure if needed to control bleeding. (Allowance for slight bleeding at the site is preferred to preclude introduction of thrombus to the vessel).
   a. Ensure that the pinch clamp is open when increasing or decreasing the pressure.
   b. Ensure while removing the sheath, the pressure applied is kept low, so that damage to the vessel or a "milking" effect is avoided.
7. If no bleeding is present, carefully loosen the belt on the puncture side of the patient without totally removing the belt from the arch. Gently roll the dome off the site and observe the site.
8. Remove the FemoStop once hemostasis is achieved.
9. Apply a gauze dressing cover with clear occlusive dressing.

F. **PROCEDURE: REMOVAL OF ARTERIAL SHEATH without a VENOUS SHEATH:**

1. Assess pedal pulse, blood pressure, heart rate, and cardiac rhythm prior to arterial sheath removal.
2. Follow the instructions for applying the belt and FemoStop.
   a. The belt may be threaded through the end of the arch before or after applying the belt.
3. Remove the sutures using the suture removal kit, if present.
4. Withdraw introducer (sheath) hub about 2cm or just enough to clear the rim of the dome.

a. Verify stopcock is parallel with the pressure tubing prior to slightly withdrawing the sheath hub.

5. Ensure the control knob of the pump is closed prior to inflating the dome
6. Inflate compression dome pressure to 60 - 80 mmHg and simultaneously remove arterial sheath.
   a. Continue to increase dome pressure 10 - 20 mmHg above the patient's systolic blood pressure or until bleeding has stopped (initial hemostasis is achieved) and pulse is not palpable or audible by doppler.
   b. If "HHH" is shown on the display, too much pressure has been applied. Open the control knob and decrease the pressure immediately.
7. Maintain inflation pressure to occlude patient's pulse for 1 - 3 minutes
   a. Do not occlude pulse for more than 3 minutes to prevent limb ischemia.
8. Monitor blood pressure, heart rate, and cardiac rhythm while maintaining inflation pressure.
   a. After 1 - 3 minutes, reduce inflation pressure slowly until a pedal pulse is present by palpation or doppler. If bleeding occurs, increase dome pressure to achieve hemostasis.
9. Maintain inflated pressure for 30 minutes ensuring hemostasis is achieved and then gradually reduce compression pressure by 10 - 20 mmHg every 2-3 minutes.
10. Gradually lower the pressure, as long as hemostasis is maintained, and observe the site for 2 – 3 minutes.
11. Continue to decrease the pressure until the dome is completely deflated. After a few minutes of observation at zero-pressure (1-2 minutes), either proceed to remove the system as described below or leave it in place at very low pressure as long as necessary to ensure continued hemostasis.
12. Continue to observe site and ensure hemostasis is maintained for a few minutes
    a. Assess blood pressure, heart rate, and cardiac rhythm.
    b. Assess patient's level of comfort.
13. Loosen the belt on the puncture side of patient and gently roll compression arch to loosen dome, taking care not to dislodge the newly formed clot and verify hemostasis time.
    a. Note the time, this is called hemostasis time.
       i. If blood is present or oozing from site, hemostasis is not maintained.
          1) Retighten belt and increase dome pressure to control bleeding.
          2) Reassess patient's blood pressure, heart rate, and cardiac rhythm.
14. Apply pressure dressing using 2 folded 4x4s over puncture site and secure with clear occlusive dressing or Elastoplast or similar tape.

F. **REMOVAL OF VENOUS AND ARTERIAL SHEATHS:**

1. Inflate dome to 20 - 30 mmHg pressure and remove venous sheath. Add additional pressure if needed to control bleeding.
2. Assess pedal pulse, blood pressure, heart rate, and cardiac rhythm prior to arterial sheath removal.
3. Continue to increase compression dome pressure to 60 - 80 mmHg and simultaneously remove arterial sheath.
   a. Continue to increase dome pressure 10 - 20 mmHg above the patient's systolic blood pressure or until bleeding has stopped and pulse is not palpable or audible by doppler.
4. Maintain inflation pressure to occlude patient's pulse for 3 minutes, do not occlude pulse for greater than 3 minutes.
5. Continue to follow steps as outlined in Arterial Sheath Removal .

G. **NURSING CARE POST SHEATH REMOVAL:**

1. Keep affected extremity straight with no hip flexion and head of bed flat or no higher than 20 degrees for a minimum of six hours or per physician's orders.
2. Monitor puncture site for bleeding or hematoma below the skin surrounding puncture site. Palpate site to detect hematoma. Monitor pedal pulse, color, temperature, and presence of tingling.

3. Assess the following, if findings are not comparable to pre-sheath removal, notify the physician:
   a. Bilateral pedal pulses (if applicable)
   b. Color and temperature of skin
   c. Presence of tingling
4. Monitor for the following complications and notify physician:
   a. Vasovagal response causing drop in blood pressure and heart rate
   b. Nausea and vomiting
   c. Hematoma or retroperitoneal bleed
      i. Patient may complain of back pain or have unexplained hypotension.

H. **PROCEDURE FOR MANAGING BLEEDING:**

1. If hemostasis is lost, ~~i.e.,~~ notify a 2nd RN to obtain a FemoStop.
2. Remove dressing, find the femoral artery and manually compress.
3. Ask the 2nd RN to activate the FemoStop as outlined in this procedure.
4. While manual pressure is maintained, place the center of the dome over the fingertip that is applying pressure.
5. Inflate the dome to 60mmHg and then start to rotate and remove fingers medially.
6. Continue to inflate dome to approximately 20 m~~m~~gHg above the patient's SBP.
   a. Do not keep the suprasystolic pressure for more than 3 minutes.
7. Remove the fingers in line with the artery and let the dome take over the pressure.
8. Reduce the pressure 10–20 mmHg every 2 – 3 minutes while ensuring hemostasis is achieved.
9. Once hemostasis is achieved, remove the FemoStop as outlined in this procedure.
10. If unable to manage bleeding, notify physician.

I. **PROCEDURE FOR MANAGING OOZING:**

1. If there is consistent oozing from the puncture tract or a hematoma use a FemoStop to regain hemostasis.
2. Prepare the FemoStop as outlined in this procedure.
3. With the dome positioned on the arteriotmy, inflate the dome to approximately 30 mmHg or until the oozing has stopped.
4. Assess the patient's blood pressure.
5. Maintain low pressures as outlined in this procedure.
6. Remove the FemoStop once hemostasis is achieved.

J. **NURSING TROUBLESHOOTING TOOLS:**

1. Target inflation pressure should be 10 – 20 mm-Hg above the systolic pressure, or higher if necessary, to control the bleeding. Exceeding pressures of 200 mmHg or greater may indicate the need to tighten the belt or reposition the dome.
2. For very obese patients:
   a. It may be necessary to tighten the belt slightly more to enhance downward compression.
   b. Fatty tissue may be displaced giving a false impression of developing hematoma.
   c. Placement of the system may not be suitable on large patients, or patients with very wide hips as the belt may be too short.

K. **DOCUMENTATION:**

1. Document the following in the electronic health (EHR) record:
   a. Circulation: pulse, temperature, color of affected extremity
   b. Condition of puncture site: bleeding, hematoma
   c. Patient response
2. Document the following in the EHR if low Femostop pressure is applied:
   a. Circulation, condition, and patient response as identified above.
   b. **Release**~~Removal~~ of Femostop **pressure** every three hours.

L. **REFERENCES:**

1. Elsevier Performance Manager Clinical Skills. (n.d.). *Arterial and Venous Sheath Removal.* Retrieved 06 23, 2020, from Elsevier Performance Manager Clinical Skills: https://point-of-care.elsevierperformancemanager.com/skills/88/extended-text?skillId=CC_076#scrollToTop
2. St. Jude Medical (2012). FemoStop tm gold: Femoral compression system. Package inserts.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/17

SUBJECT: ~~Glucose Monitoring During Exercise Therapy for Patients with Diabetes~~ Diabetic Management of Phase II Cardiac Rehabilitation Participants During Exercise Therapy

REVISION DATE~~(S)~~: 04/20

Patient Care Services Content Expert Approval:	~~12/19~~03/~~23~~4/23
Clinical Policies and Procedures Approval:	~~01/20~~05/23
Nursinge Leadership~~Executive Committee~~ Approval:	~~02/20~~06/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~07/23
Administration Approval:	~~04/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

~~1)~~1. To allow for the early detection and prevention of hypoglycemia or hyperglycemia in outpatient cardiac rehabilitation participants with a diagnosis of diabetes mellitus. ~~To provide safe, therapeutic care for outpatients with diabetes during their exercise training session in Tri-City Healthcare District (TCHD) rehabilitation facilities.~~

B. POLICY~~:~~

1. All Phase II insulin-dependent diabetic patients will have their blood glucose level checked before and after each exercise session for the duration of cardiac rehabilitation.
2. All Phase II non-insulin-dependent diabetic patients will have their blood glucose level checked before and after their first three exercise sessions only, unless symptomatic. ~~All phase two (2) patients **non insulin dependent diabetic patients** who are **taking oral diabetes medications but not taking** taking insulin or oral diabetes medications which can cause hypoglycemia will have their blood glucose level checked before and after exercise during their first three (3) exercise sessions by the staff trained and competent (Registered Nurses or Respiratory Care Practitioner (RCP)) in the use of the Nova Stat Strip glucose monitoring system.~~

~~a) If blood sugars are stable (between 90-300 mg/dL) after 3 visits pre and post exercise, non insulin dependent patients will no longer need to continue having checks (unless symptomatic).~~

~~b) If blood sugars are unstable (under 90 or over 300 mg/dL), patient must make an appointment with their Primary Care Provider (PCP) to have their medication and diet reviewed. The patient will need to bring back a note from PCP stating he/she is cleared to return to exercise.~~

~~The RN/RCP will again check blood sugars pre and post exercise over the next 3 visits. If stable (90-300 mg/dL), patient does not need to continue being checked. If unstable (below 90 or above 300 mg/dL) patient will again need clearance from PCP to return to exercise.~~

~~c) **All insulin dependent diabetic patients will have their blood glucose level checked before and after exercise for the duration of cardiac rehabilitation.**~~

C. PROCEDURE:

1. **Registered Nurses (RN's), trained and competent in the use of the current glucose monitoring system used at the facility, shall test the participants blood sugar before beginning their exercise session and immediately post-exercise.**
~~RN/RCP on staff shall test diabetic patients' pre and post exercise blood sugars for their first 3 visits followed immediately with action based on results.~~
~~**Insulin dependent diabetic patients for the duration of cardiac rehabilitation**~~
~~**Non-insulin dependent patients for their first 3 visits.**~~
~~d) **If blood sugars are stable (between 90-300 mg/dL) after 3 visits pre and post exercise, non insulin dependent patients will no longer need to continue having checks (unless symptomatic).**~~
2. If -blood glucose is less than ~~90~~**100** mg/dL, the patient shall ~~eat a pre-exercise snack of~~ **consume** 15 grams of carbohydrate which they are instructed to bring to every session. Juice, glucose tabs and gel, granola bars, peanut butter and graham crackers are kept in the department in case the patient did not bring **their**~~his/her~~ own snack. (Examples of fast acting carbohydrate are ½ cup orange juice, 1 cup skim milk, 3-4 glucose tabs or glucose gel equal to 15 grams, 8-10 lifesaver candies).
3. ~~For patients with a pre exercise blood sugar less than 90 mg/dL who have eaten a 15 gram carbohydrate snack, w~~**W**ait 15 minutes after snack **is consumed** and recheck blood **glucose.**~~sugar~~.
~~e)~~**4.** If **blood glucose remains** below ~~90~~**100mg/dL**, repeat treatment. Notify **the patient's primary care** physician **(PCP)** ~~for~~ **of** repeated low blood sugar levels.
5. If blood glucose is greater than 300-mg/dL, ~~patient may not exercise that day.~~**no exercise will be allowed that day and the** ~~Notify physician if~~ patient**'s PCP will be notified** ~~is~~**they were** unable to exercise due to **an** elevated blood glucose level.
6. ~~If the patient is driving him/herself, the post exercise blood sugar should be 90 mg/dL or greater. If the post exercise~~ **After exercise, if the** blood ~~sugar~~ **glucose** is less than ~~90~~**100** mg/dL ~~he/she should have a snack of~~ 15 grams **of** carbohydrate **should be consumed** and **the blood glucose** re-check**ed** ~~in~~**after** 15 minutes. ~~and r~~**R**epeat until blood **glucose**~~sugar~~ is ~~90~~**100 mg/dL** or greater before ~~being~~ discharg**inged** home.
7. **For non-insulin dependent diabetics, blood glucose monitoring may be discontinued after 3 visits if blood glucose was between the parameters of 100 mg/DL-300 mg/dL.**
8. **Blood glucose levels will be checked on insulin-dependent diabetic participants for the duration of their program.**

D. REFERENCES:

~~f)~~**1. American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). (2021). Guidelines for cardiac rehabilitation programs. (6th ed.). Human Kinetics.**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HAZARDOUS DRUGS**
Purpose:	To ensure the safety of employees/patients during the handling of hazardous drugs within Tri-City Healthcare District (TCHD)
Supportive Data:	National Institute of Occupational Safety and Health (NIOSH) and Center for Disease Control (CDC)
Equipment:	Cytotoxic bin, yellow chemo waste bags, N-95 mask, double gloves, gown, splash goggles or face shield, protective shoe covers

A. **DEFINITION(S):**

1. Hazardous drugs (HD) : As defined by the NIOSH Working Group, drugs considered hazardous include those that exhibit one or more of the following six characteristics in humans or animals:
   a. Carcinogenicity
   b. Teratogenicity or other development toxicity
   c. Reproductive toxicity in humans
   d. Organ toxicity at low doses in humans or animals
   e. Genotoxicity – the ability to cause a change or mutation in genetic material.
   f. Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria
2. NIOSH HD risk stratification:
   a. Group 1: Antineoplastic drugs (American Hospital Formulary Service [AHFS] Classification 10:00).
   b. Group 2: Non-antineoplastic drugs that meet one or more of the National Institute for Occupational Safety and Health (NIOSH) criteria for a hazardous drug.
   c. Group 3: Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breast feeding, because some of these drugs may be present in breast milk.
3. HD consists of certain antineoplastics such as chemotherapy, as well as medications to treat disease states other than cancer.

B. **POLICY:**

1. This policy applies to TCHD staff handling or administering hazardous drugs. Additionally, this policy pertains to TCHD staff handling the bodily fluids of admitted patients who received these drugs during their hospital stay.
2. Appropriate personal protective equipment (PPE) must be worn when handling HD including during receipt, storage, transport, compounding (sterile and nonsterile), administration, deactivation/decontamination, cleaning, disinfecting, spill control and waste.
   a. See Related Document: Hazardous Drugs, Personal Protective Equipment When Handling HD.
      i. Chemo-safe gloves must meet American Society for Testing and Materials (ASTM) standard D6978 (or its successor).
3. Only a TCHD registered nurse (RN) who has completed the **computer based learning** ~~NetLearning~~ ~~"~~Hazardous Drugs~~"~~ module may administer a hazardous drug.
4. Identification of HD:
   a. HD are identified based on the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.
   b. Pharmacy maintains a list of the HD (see Related Document: Hazardous Drug List).
      i. The HD list is reviewed and updated at least annually.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
08/10, 02/11, 03/12, 06/16, 02/17, 0	03/12, 07/16, 08/17, 05/18	03/12, 07/16, 08/17, 05/18, 10/20, **05/23**	n/a	09/16, 07/18, 05/21, **05/23**	04/12, 09/16, 08/18, 07/21, **06/23**	09/18, 09/21, **08/23**	05/12, 10/16, n/a	05/12, 11/16, 09/18, 09/21

ii. An assessment of risk is performed at least annually to determine alternative containment strategies and/or work practices for Group 3 HD or any other HD as determined by TCHD to minimize occupational exposure.

c. HD identified by the facility are communicated to all staff that may potentially handle these agents. Methods of communication include, but are not limited to:
   i. Ready access to the hazardous drug list
   ii. Ancillary labels
   iii. Pyxis alerts
   iv. Electronic Medication Administration Record (eMAR) comments

5. Precautions must be taken during administration and until 48 hours after last dose for Group 1 HDs
   a. Equipment and patient care items which come into contact with these drugs or with body secretions from patients within 48 hours post administration, are considered contaminated and must be handled and disposed of as such.

C. **PREPARATION OF HAZARDOUS DRUGS:**

1. Injectables:
   a. Group 1 and 2
      i. HD will be prepared by pharmacy under a chemo hood.
   b. Group 3
      i. HD may be prepared in positive pressure buffer room using acceptable practices for non-hazardous medications.
2. Non-injectables:
   a. Group 1 and 2
   b. HD will be handled in the following manner:
      i. Chemo-safe gloves will be used during routine handling of Group 1 and 2 HD and contaminated equipment.
      ii. Counting or repackaging (unit dosing) of HD tablets and capsules under a hood is not required.
      iii. Any preparation including pouring and counting will be done with equipment that is wiped down after use with HD.
         1) Equipment that enters the chemo hood should be dedicated to this use only.
      iv. Medications may not be cut, crushed, or diluted on the nursing unit.
         1) Cutting or crushing of hazardous oral medications will be done only under a chemotherapy hood by pharmacy.
      v. Compounded liquid (solution or crushed medication mixed in a slurry) medications will be:
         1) Prepared in the chemotherapy hood by pharmacy
         2) Dispensed in an oral syringe
         3) Provided to patients from pharmacy when a patient cannot swallow the intact oral solid dosage form (e.g. NGT)
         4) Dispensed in a sealable plastic bag in order to contain any inadvertent contamination.
   c. Group 3
      i. HD may be prepared the same as non-hazardous medications.
         1) It is recommended that men and women of child bearing age or women who are pregnant or breastfeeding:
            a) Use double chemo-safe gloves during handling and administration.
            b) Use mask when crushing or splitting. May wear gown if risk of splashing.
               i) It is not required to crush or split in chemo hood.

c) Take special care to wipe down equipment before use if risk of contamination.

D. **TRANSPORTING HAZARDOUS DRUGS:**

1. All liquid (parenteral and oral) Group 1 and 2 HD shall be transported as follows:
   a. In a sealable plastic bag
   b. Group 1 drugs shall be transported in a chemo cooler, **as needed,** with a spill kit and delivered to authorized floors only.
2. Liquid and solid Group 3 HD may be delivered as standard non-HD medications.

E. **ADMINISTERING HAZARDOUS DRUGS:**

1. When handling and or/administering Group 1 and 2 HD, personnel shall do the following:
   a. Don gown if there is risk of spills or splashing. Gowns should be changed if contaminated with drugs or excreta from patients.
   b. Don two pairs of double chemo-safe gloves. A single pair of chemo-safe gloves may be worn if administering an intact capsule or tablet.
   c. Never score or crush Group 1 or 2 HD (prevents inhalation of the drug).
   d. Notify pharmacy if Group 1 or 2 HD must be administered via gastric tube (i.e., nasogastric or oral gastric small bore feeding tube).
   e. Ensure appropriate cytotoxic waste container (bag or puncture-proof container)is available on the unit (i.e., medication room or designated area).
   f. Document all hazardous drug patient education in the medical record

F. **HAZARDOUS DRUG DISPOSAL AND WASTE:**

1. Refer to Administrative Policy: Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions 276 and TCHD Waste Disposal Guidelines Grid.

G. **HD EXPOSURES AND PREVENTION MANAGEMENT:**

1. Skin care of incontinent adult receiving HD:
   a. Clean patient's skin after voiding or having a bowel movement.
   b. Apply protective barrier ointment or cream before diapering.
2. In the event of skin exposure to a hazardous drug, remove any contaminated garment and immediately wash contaminated skin with soap and water.
3. In case of eye exposure, immediately flush the eye with saline solution or water for at least five (5) minutes.
4. Report any exposures or spills to the Nursing Leadership/Charge Nurse/Supervisor.
5. Report any employee exposure to employee health services and/or emergency department.
   a. Complete an Illness/Injury Investigation Report.
6. Report patient exposures to the patient's healthcare provider and per Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396.

H. **HANDLING OF GROUP 1 AND 2 HD – PHARMACY DEPARTMENT:**

1. A designated person who is qualified and trained will oversee entity compliance with United States Pharmacopeia (USP) 800 and all applicable laws, regulations and standards, as well as develop and implement appropriate procedures.
2. Signs designating HD handling areas will be displayed before the entrance.
   a. Access to these areas will be restricted to authorized personnel only.
3. Receiving:
   a. Designated areas must be available for receipt and unpacking of HD.
   b. HD must be unpacked in an area that is neutral/normal or negative pressure relative to the surrounding areas.
   c. Chemotherapy gloves must be worn when unpacking HD.
   d. Receiving and handling of damaged HD shipping containers will be performed as per USP 800 requirements.

4. Storage:
   a. Group 1 and 2 HD that require compounding, must be stored in the negative pressure buffer room.
   b. Refrigerated Group 1 and 2 HD must be stored in a dedicated refrigerator in the negative pressure buffer room.
      i. Exhaust should be located adjacent to the refrigerator's compressor and behind the refrigerator. Solid state engineering (no compressor) may be considered.
   c. Group 2 and 3, as well as final dosage forms of Group 1 HD may be stored with other inventory.
   d. Drug bins, shelves, and storage areas bear distinctive labels identifying those drugs requiring special handling precautions.
5. Competency Assessment:
   a. Training must occur before personnel independently handle HD:
      i. Overview of TCHD list of HD and their risks.
      ii. Review of the TCHDs' standards of practice related to handling of HD.
      iii. Proper use of PPE.
      iv. Proper use of equipment and devices.
      v. Response to known or suspected HD exposure.
      vi. Spill management.
      vii. Proper disposal of HD and trace-contaminated material.
   b. Competency will be reassessed annually.

I. RELATED DOCUMENT(S):

1. Administrative Policy: 396 Incident Report-Quality Review Report (QRR) RL Solutions
2. Patient Care Services Policy: Chemotherapy Prescribing, Processing and Preparation
3. Patient Care Services Procedure: Chemotherapy Administration
4. Patient Care Services Procedure: Disposal of Chemotherapy Waste
5. Patient Care Services Procedure: Chemotherapy Exposure, Spills and Handling of Linens Contaminated With Chemotherapeutic Agents And Body Fluids, Accidental Exposure To Radioactive Body Fluids
6. Pharmacy Policy: Sterile Compounding
7. TCHD Hazardous Drug List
8. TCHD Hazardous Drugs, Personal Protective Equipment When Handling HD
9. TCHD Waste Disposal Guidelines
10. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan

J. REFERENCE(S):

1. American Hospital Formulary Service (2019). Drug Information.
2. Department of Health and Human Services. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings (2016). http://www.cdc.gov/niosh/topics/antineoplastic/pdf/hazardous-drugs-list_2016-161.pdf.
3. ~~National Institute for Occupational Safety and Health. (2004). Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings. http://www.cdc.gov/niosh/docs/2004-165/#c~~
4.**3.** US Pharmacopeial Convention (2019) USP Compounding Compendium. USP General Chapter <800> *Hazardous Drugs–Handling in Healthcare Settings*

Hazardous Drugs (HD), Personal Protective Equipment When Handling HD

Personal Protective Equipment When Handling HD†					
Activity/Description	**Double Gloves**	**Chemotherapy Gown**	**Hair, Beard, Face Mask, Shoe Covers**	**Eye & Face Protection**	**Respiratory Protection**
Receiving Suspected / Broken Supplies	✓	✓	✓	✓	✓
Non-Sterile HD Compounding	✓	✓	✓		
Sterile HD Compounding	✓	✓	✓		
Administering Liquid HD	✓	✓		Only when splashing is possible	
Administering Solid HD	✓				
Crushing/Splitting*	✓	✓	✓		
Standard or Routine Clean-up	✓	✓	✓	Only when cleaning at or above eye level	
Collection and Disposal of Patient Waste	✓	✓		Only when splashing is possible	
Spills	✓	✓	✓	✓	✓

†Personal protective equipment is optional for Group 3
*Only Group 3 can by crushed or split outside the Pharmacy Department.

Tri-City Healthcare District Hazardous Drug List

Hazardous Group 1: Antineoplastic drugs

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Abiraterone	Zytiga	Oral	Antineoplastic agent
Ado-trastuzumab emtansine	Kadcyla	Inj	Antineoplastic agent
Afatinib Dimaleate	Gilotrif	Oral	Antineoplastic agent
Altretamine	Hexalen	Oral	Antineoplastic agent
Amsacrine	Amsidine	Inj	Not in AHFS (Antineoplastic agent)
Anastrozole	Arimidex	Oral	Antineoplastic agent
Arsenic trioxide	Trisenox	Inj	Antineoplastic agent
Axitinib	Inlyta	Oral	Antineoplastic agent
Azacitidine	Vidaza	Inj	Antineoplastic agent
Bacillus Calmette-Guerin	BCG	Inj	Vaccine
Belinostat	Beleodaq	Inj	Antineoplastic agent
Bendamustine HCL	Treanda	Inj	Antineoplastic agent
Bexarotene	Targretin	Oral, Topical	Antineoplastic agent
Bicalutamide	Casodex	Oral	Antineoplastic agent
Bleomycin	Blenoxane	Inj	Antineoplastic agent
Bortezomib	Velcade	Inj	Antineoplastic agent
Bosutinib	Bosulif	Oral	Antineoplastic agent
Brentuximab vedotin	Adcetris	Inj	Antineoplastic agent
Busulfan	Busulfex	Inj, Oral	Antineoplastic agent
Cabazitaxel	Jevtana	Inj	Antineoplastic agent
Cabozantinib	Cometriq	Oral	Antineoplastic agent
Capecitabine	Xeloda	Oral	Antineoplastic agent
Carboplatin	Paraplatin	Inj	Antineoplastic agent
Carfilzomib	Kyprolis	Inj	Antineoplastic agent
Carmustine	BiCNU	Inj	Antineoplastic agent
Ceritinib	Zykadia	Oral	Antineoplastic agent
Chlorambucil	Leukeran	Oral	Antineoplastic agent
Cisplatin	Platinol	Inj	Antineoplastic agent
Cladribine	Leustatin	Inj	Antineoplastic agent
Clofarabine	Clolar	Inj	Antineoplastic agent
Crizotinib	Xalkori	Oral	Antineoplastic agent
Cyclophosphamide	Cytoxan	Oral, Inj	Antineoplastic agent
Cytarabine	Ara-C, Depocyt	Inj	Antineoplastic agent
Dabrafenib	Tafinlar	Oral	Antineoplastic agent
Dacarbazine	DTIC	Inj	Antineoplastic agent
Dactinomycin	Cosmegen	Inj	Antineoplastic agent
Dasatinib	Sprycel	Oral	Antineoplastic agent
Daunorubicin HCl	Cerubidine	Inj	Antineoplastic agent
Decitibine	Dacogen	Inj	Antineoplastic agent
Degarelix	Firmagon	Inj	Antineoplastic agent
Docetaxel	Taxotere, Docefrez	Inj	Antineoplastic agent
Doxorubicin	Adriamycin, Doxil	Inj	Antineoplastic agent
Enzalutamide	Xtandi	Oral	Antineoplastic agent (not in AHFS)
Epirubicin	Ellence	Inj	Antineoplastic agent
Eribulin mesylate	Halaven	Inj	Antineoplastic agent

Tri-City Healthcare District Hazardous Drug List

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Erlotinib	Tarceva	Oral	Antineoplastic
Estramustine phosphate	EMCYT	Oral	Antineoplastic agent
Etoposide	VP-16, Vepesid	Inj, Oral	Antineoplastic agent
Everolimus	Afinitor, Zortress	Oral	Antineoplastic agent
Exemestane	Aromasin	Oral	Antineoplastic agent
Floxuridine	FUDR	Inj	Antineoplastic agent
Fludarabine	Fludara	Inj	Antineoplastic agent
Fluorouracil	5-FU, Adrucil, Carac, Fluoroplex, Efudex	Inj, Topical	Antineoplastic agent
Flutamide	Eulexin	Oral	Antineoplastic agent
Fulvestrant	Faslodex	Inj	Antineoplastic agent
Gefitinib	Iressa	Oral	Antineoplastic agent
Gemcitabine	Gemzar	Inj	Antineoplastic agent
Gemtuzumab ozogamycin	Mylotarg	Inj	Antineoplastic agent
Goserelin	Zoladex	Inj	Antineoplastic agent (hormone modifier)
Histrelin	Supprelin	Inj	Antineoplastic agent (hormone modifier)
Hydroxyurea	Hydrea, Droxia	Oral	Antineoplastic agent
Ibrutinib	Imbruvica	Oral	Antineoplastic agent
Idarubicin	Idamycin	Inj	Antineoplastic agent (not in AHFS)
Idelalisib	Zydelig	Oral	Antineoplastic agent
Ifosfamide	Ifex	Inj	Antineoplastic agent
Imatinib mesylate	Gleevec	Oral	Antineoplastic agent
Irinotecan HCl	Camptosar	Inj	Antineoplastic agent
Ixabepilone	Ixempra	Inj	Antineoplastic agent
Ixazomib	Ninlaro	Oral	Antineoplastic agent
Lapatinib ditosylate	Tykerb	Oral	Antineoplastic agent
Lenalidomide	Revlimid	Oral	Biological response modifier
Lenvatinib	Lenvima	Oral	Antineoplastic agent
Letrozole	Femara	Oral	Antineoplastic agent
Leuprolide acetate	Lupron, Eligard, Viadur	Inj	Antineoplastic agent
Lomustine	CEENU	Oral	Antineoplastic agent
Mechlorethamine	Mustargen, Valchlor	Inj, Topical	Antineoplastic agent
Megestrol	Megace	Oral	Hormone modifier (AHFS=antineoplastic)
Melphalan	Alkeran	Oral, Inj	Antineoplastic agent
Mercaptopurine	Purinethol, Purixan	Oral	Antineoplastic agent
Methotrexate	Trexall, Rheumatrex, Otrexup	Oral, Inj	Antineoplastic agent
Mitomycin	Mutamycin	Inj	Antineoplastic agent
Mitotane	Lysodren	Oral	Antineoplastic agent
Mitoxantrone HCl	Novantrone	Inj	Antineoplastic agent
Nelarabine	Arranon	Inj	Antineoplastic agent
Nilotinib	Tasigna	Oral	Antineoplastic agent
Nilutamide	Nilandron	Oral	Antineoplastic agent
Olaparib	Lynparza	Oral	Antineoplastic agent

Tri-City Healthcare District Hazardous Drug List

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Omacetaxine mepesuccinate	Synribo	Inj	Antineoplastic agent
Oxaliplatin	Eloxatin	Inj	Antineoplastic agent
Paclitaxel	Taxol/Abraxane	Inj	Antineoplastic agent
Palbociclib	Ibrance	Oral	Antineoplastic agent
Panobinostat	Farydak	Oral	Antineoplastic agent
Pazopanib HCL	Votrient	Oral	Antineoplastic agent
Pemetrexed	Alimta	Inj	Antineoplastic agent
Pentostatin	Nipent	Inj	Antineoplastic agent
Pomalidomide	Pomalyst	Oral	Antineoplastic agent
Ponatinib	Inclusig	Oral	Antineoplastic agent
Pralatrexate	Folotyn	Inj	Antineoplastic agent
Procarbazine	Matulane	Oral	Antineoplastic agent
Regorafenib	Stivarga	Oral	Antineoplastic agent
Romidepsin	Istodax	Inj	Antineoplastic agent
Ruxolitinib	Jakafi	Oral	Antineoplastic agent
Sonidegib	Odomzo	Oral	Antineoplastic agent
Sorafenib	Nexavar	Oral	Antineoplastic agent
Streptozocin	Zanosar	Inj	Antineoplastic agent
Sunitinib malate	Sutent	Oral	Antineoplastic agent
Tamoxifen	Nolvadex	Oral	Antineoplastic agent
Temozolomide	Temodar	Inj, Oral	Antineoplastic agent
Temsirolimus	Torisel	Inj	Antineoplastic agent
Teniposide	Vumon	Inj	Antineoplastic agent
Thalidomide	Thalomid	Oral	Immunomodulator
Thioguanine	Tabloid	Oral	Antineoplastic agent
Thiotepa	Thioplex	Inj	Antineoplastic agent
Topotecan	Hycamtin	Oral, Inj	Antineoplastic agent
Toremifene citrate	Fareston	Oral	Antineoplastic agent
Trametinib Dimethyl Sulfoxide	Mekinist	Oral	Antineoplastic agent
Tretinoin	Vesanoid, ATRA	Oral, Topical	Antineoplastic agent
Trifluridine/tipiracil (combination only)	Lonsurf	Oral	Antineoplastic agent
Trimetrexate	n/a	Inj	Antineoplastic agent
Triptorelin	Trelstar	Inj	Antineoplastic agent
Valrubicin	Valstar	Inj	Antineoplastic agent
Vandetanib	Caprelsa	Oral	Antineoplastic agent
Vemurafenib	Zelboraf	Oral	Antineoplastic agent
VinBLAStine sulfate	Velban	Inj	Antineoplastic agent
VinCRIStine sulfate	Oncovin	Inj	Antineoplastic agent
Vinorelbine tartarate	Navelbine	Inj	Antineoplastic agent
Vismodegib	Erivedge	Oral	Antineoplastic agent
Vorinostat	Zolinza	Oral	Antineoplastic agent
Ziv-aflibercept	Zaltrap	Inj	Antineoplastic agent

Hazardous Group 2: Non-antineoplastic drugs that meet one or more of the NIOSH criteria for a hazardous drug

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Azathioprine	Imuran	Oral, Inj	Immunosuppressant
Cidofovir	Vistide	Inj	Antivirals

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Cyclosporine	Neoral, Sandimmune, Restasis	Oral, Inj, Opth	Immunosuppressive agent
Deferiprone	Ferriprox	Oral	Heavy metal antagonist
Dexrazoxane	Zinecard, Totect	Inj	Protective agent
Fingolimod	Gilenya	Oral	Biological response modifier
Leflunomide	Arava	Oral	Disease modifying antirheumatic agent
Liraglutide recombinant	Victoza	Inj	Antidiabetic
Mycophenolate mofetil	Myfortic, Cellcept	Oral, Inj	Immunosuppressive agent
Mycophenolic acid	Myfortic	Oral	Immunosuppressive agent
Nevirapine	Viramune	Oral	Antiviral
Oxcarbazepine	Trileptal	Oral	Anticonvulsants, misc
Phenoxybenzamine HCL	Dibenzyline	Oral	Non selective antiadrenergic blocking agent
Sirolimus	Rapamune	Oral	Immunosuppresive agent
Rasagiline	**Azilect**	**Oral**	**Antiparkinsonian agent**
Tacrolimus	Prograf, Hecoria, Astagraf, Protopic	Oral, Inj, Topical	Unclassified therapeutic agent (immunosuppressant)
Teriflunomide	Aubagio	Oral	Immunomodulatory agent
Tofacitinib	Xeljanz	Oral	Disease modifying antirheumatic drugs
Zidovudine	Retrovir, ZDV, Combivir, Trizivir (in combination with Abacavir and Lamivudine)	Oral, Inj	Antiretroviral agent

Hazardous Group 3: Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breast feeding, because some of these drugs may be present in breast milk.

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Abacavir	Ziagen	Oral	Nucleoside and reverse transcriptase inhibitors
Acitretin	Soriatane	Oral	Dermatological agent
Alitretinoin	Panretin	Topical	Skin and mucous membrane agent, miscellaneous
Ambrisentan	Letairis	Oral	Vasodilating agent
Apomorphine	Apokyn	Inj	Dopamine agonist
Bazedoxifene Acetate	Duavee	Oral	Hormone modifier
Bosentan	Tracleer	Oral	Vasodilating agent
Cabergoline	Dostinex	Oral	Ergot derived dopamine receptor agonist
Carbamazepine	Tegretol	Oral	CNS agent
Cetrorelix acetate	Cetrotide	Inj	Gonadotropin-releasing hormone antagonist
Chloramphenicol	Chloromycetin	Inj	Antibiotic
Choriogonadotropin alfa	Ovidrel	Inj	Gonadotropins
Clomiphene	Clomid	Inj	Ovulation stimulant

Tri-City Healthcare District Hazardous Drug List

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Clonazepam	Klonopin	Oral	Benzodiazepine
Colchicine	Colcrys	Oral, Inj	Antigout Agent
Dinoprostone	Cervidil, Prostin, Prepidil	Topical	Oxytocic
Divalproex Na	Depakote	Oral	CNS agent
Dronedarone HCL	Multaq	Oral	Antiarrythmic
Dutasteride	Avodart, Jalyn	Oral	5-alpha reductase inhibitor
Ergonovine/Methylergonovine	Methergine	Oral, Inj	Oxytocic
Eslicarbazepine acetate	Aptiom	Oral	Anticonvulsant
Estradiol	n/a	Inj, Oral, Topical	Estrogen
Estrogen-progestin combinations	n/a	Oral	Contraceptive
Estrogens, conjugated	Premarin	Oral, Inj	Estrogen
Estrogens, esterified	Estratest	Oral	Estrogen
Estropipate	Ogen	Oral	Estrogen
Finasteride	Proscar	Oral	5-alpha reductase inhibitor
Fluconazole	Diflucan	Oral, Inj	Antiinfective agent
Fluoxymesterone	Androxy, Halotestin	Oral	Androgen
Fosphenytoin	Cerebyx	Inj	Hydantoin
Ganciclovir	Cytovene, Zirgan	Oral, Opth, Inj	Antiviral
Ganirelix acetate	Ganirelix, Antagon	Inj	Gonadotropin-releasing hormone antagonist
Human chorionic gonadotropin (HCG)	Pregnyl, Novarel	Inj	Gonadotropin
Icatibant	Firazyr	Inj	Bradykinin B2 receptor agonist
Lomitapide	Juxtapid	Oral	Antilipemic agents, miscellaneous
Macitentan	Opsumit	Oral	Endothelin receptor antagonist
Medroxyprogesterone Acetate	Depo-Provera, Provera	Inj, Oral	Progestins
Mentropins	Menopur, Repronex	Inj	Gonadotropins
Methimazole	Tapazole	Oral	Antithyroid agent
Methyltestosterone	Testred, Android, Methitest	Oral	Androgens
Mifepristone	Mifeprex, Korlym	Oral	Oxytocics
Miltefosine	Impavido	Oral	Antiprotazoal agent
Misoprostol	Cytotec	Oral, Topical	Prostaglandin analog
Nafarelin	Synarel	Nasal	Gonadotropin
Ospemifene	Osphena	Oral	Estrogen agonists-antagonists
Oxytocin	Pitocin	Inj	Oxytocic
Palifermin	Kepivance	Inj	Cell stimulants and proliferants
Paliperidone	Invega	Oral, Inj	Atypical antipsychotics
Pamidronate	Aredia	Inj	Bone resorption inhibitors
Paroxetine	Paxil, Brisdelle, Pexeva	Oral	Selective serotonin reuptake inhibitor
Pasireotide	Signifor	Inj	Somostatin agonists
Pentetate calcium trisodium	Ca-DTPA	Inj	Not in AHFS
Pertuzumab	Perjeta	Inj	Antineoplastic agent
Phenytoin	Phenytek, Dilantin	Oral, Inj	CNS agent

Tri-City Healthcare District Hazardous Drug List

Generic Name	Brand Name	Form	AHFS-Therapeutic Classification
Plerixafor	Mozobil	Inj	Hematopoietic agent
Progesterone	Prometrium	Oral	Progestins
Progestins	Various oral contraceptives	Oral	Contraceptives
Propylthiouracil	PTU	Oral	Antithyroid agent
Raloxifene	Evista	Oral	Estrogen agonists-antagonists
Ribavirin	Rebetol, Moderiba, Copegus, Virazole	Oral, Inh	Antiviral
Riociguat	Adempas	Oral	Vasodilating agent
Risperidone	Risperdal	Oral, Inj	Atypical antipyschotic
Spironolactone	Aldactone	Oral	Diuretic
Telavancin	Vibativ	Inj	Glycopeptide
Temazepam	Restoril	Oral	Benzodiazepine
Testosterone	n/a	Inj, Topical	Androgens
Topiramate	Topamax, Qudexy XR, Topiragen, Trokendi XR	Oral	Antiepileptic
Trastuzumab	Herceptin	Inj	Antineoplastic agent
Ulipristal acetate	Ella	Oral	Contraceptive
Valganciclovir	Valcyte	Oral	Antiviral
Valproate Na- IV	Depacone	Inj	Anticonvulsants, misc
Valproic Acid	Depakene	Oral, Inj	Anticonvulsants, misc
Vigabatrin	Sabril	Oral	Anticonvulsants, misc
Voriconazole	Vfend	Oral, Inj	Antifungal
Warfarin	Coumadin	Oral	Anticoagulant
Ziprasidone HCL	Geodon	Oral, Inj	Atypical antipsychotic
Zoledronic acid	Zometa, Reclast	Inj	Bone resorption inhibitors
Zonisamide	Zonegran	Oral	Anticonvulsants, misc

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/81**	**SUBJECT:**	**Medications Brought In By the Patient**
REVISION DATE:	**09/97; 12/00; 03/01; 02/05; 04/05; 03/07; 10/09; 06/11; 08/13; 10/17, 09/20**		

Patient Care Services Content Expert Approval:	**~~03/20~~02/23**
Clinical Policies and Procedures Approval:	**~~05/20~~03/23**
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Pharmacy and Therapeutics Approval:	**~~07/20~~05/23**
Medical Executive Committee Approval:	**~~08/20~~06/23**
Administration Approval:	**~~09/20~~08/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/20**

A. **POLICY:**

1. As part of the Conditions of Admission, the patient understands and agrees personal medications (including non-prescription, prescription, and herbal) will not be consumed by patient during their hospital stay.
   a. This applies to both inpatient and outpatient services.
   b. The hospital pharmacy department may request a patient provide their personal medications for administration if the medication is unobtainable by the hospital pharmacy department.
   c. During the admission process, patients are asked to provide all medications (including non-prescription, prescription, and herbal) that he/she is currently taking.
   d. After review of the patient's personal medications by admitting staff, medications will be returned to the patient's family or patient's representative for storage at patients' residence. If the patient does not have family members or a representative present upon admission, the hospital pharmacy department will store the medications in the pharmacy department.
2. If it is deemed necessary to administer a patient's own medication while the patient is in the hospital (inpatient or outpatient) the following conditions must be met before the medication is administered to the patient:
   a. The patient's physician has ordered the drugs and the order has been entered in the patient's medical record. The order shall contain the name of the drug, strength, route, frequency, and the time the order was written.
   b. The medication containers are clearly and properly labeled.
   c. The contents of the containers have been examined and positively identified after arrival at the hospital, by the patient's physician or the hospital pharmacist. The pharmacist or physician will initial the vial, attach the medication checked by label, and affix the label to the medication container.
   d. The integrity of the medication has been visually evaluated by the pharmacist or the physician.
   e. If the pharmacist or physician cannot positively identify or assure the medications' integrity, administration of the medication is not allowed.
3. All medications are administered by the nurse and recorded on the patients' medication administration record.

4. If the medication is a non-controlled medication, it shall be stored in a secure area at the nursing station (locked medication room). If the medication is a controlled medication, it shall be stored in the Pyxis Medstation. The pharmacist shall inventory and add the controlled drugs to the Pyxis Medstation under patient's own medications (POM's). If a Pyxis Medstation is not available, the controlled medication will be stored in a locked, secure area at the nursing station and the medication counted and remaining drug noted after every dispensation to the patient to maintain accountability.
5. Parenteral medications may not be administered to patients unless prepared by or acquired by the Pharmacy Department at Tri-City Medical Center.
6. When the patient's own medications are brought into the hospital, a family member shall take the medications home.
7. When patient's own medication(s) cannot be taken home, the nurse shall:
   a. Place a patient label on all 3 pages of the Patient's Own Medication Record form.
   b. List medications by name on the form:
      i. Any controlled substances need to be verified and counted by a nurse and pharmacist or pharmacy technician. Pharmacy personnel will provide a counting tray.
      ii. Non-controlled drugs do not need to be counted.
      iii. Indicate if any bottles are empty upon receipt.
   c. Call pharmacy to pick up patient's own medications and the attached form. When the pharmacy technician or the pharmacist arrives to pick up the medications, the nurse and pharmacy personnel shall verify that the non-controlled drugs listed on the form are present and will verify and count any controlled drugs that may be listed on the form. The quantity of the controlled drug counted shall be listed on the form attached to the bag. The nurse and pharmacy personnel shall each sign and date the form.
   d. Patients own medications are to be stored inside of security bags using unique numbered locks. The lock number shall be transcribed onto the form after verification of the medications is complete. Then the pharmacy personnel and nurse shall label the bag with a patient sticker and place the patient's own medications inside of the security bag which will be locked in the presence of both parties.
   e. Document that patient's meds have been stored in Pharmacy in the medical record. Give pink copy to patient, and place yellow copy in chart.
8. When patient is discharged:
   a. The nurse shall ensure the pharmacy is notified to retrieve patient's medications upon discharge.
   b. If patient's own medications are ordered as discharge medications, the nurse shall instruct the patient accordingly.
   c. Pharmacy personnel will deliver the bag of patient's own meds to the nursing unit. Pharmacy personnel with the discharging nurse shall verify the lock number and that no tampering of the bag has occurred.
   d. The patient's own medications shall be returned to the patient with their other belongings.
   e. The patient's own medications that are not retrieved will be disposed of per Pharmacy Policy: Unusable Medications.

B. **RELATED DOCUMENT(S):**
1. Pharmacy Policy: Unusable Medications

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Patient and Family Education

REVISION DATE: 06/03, 04/06, 10/07, 02/09, 06/11, 08/14, 04/20, 07/17, 08/20

Patient Care Services Content Expert Approval:	~~04/20~~05/23
Clinical Policies and Procedures Approval:	~~05/20~~06/23
Nursing Leadership ~~Committee~~ Approval:	~~06/20~~08/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval	08/20

A. **PURPOSE:**

1. To ensure every patient is provided with the necessary information to address individual health needs and challenges.

B. **DEFINITIONS:**

1. Patient – refers to patient, family, caregiver, and significant other(s) who may benefit from patient education.

C. **POLICY:**

1. Healthcare providers shall ensure the patient receives education and training specific to the patient's needs and abilities and as appropriate to the care, treatment, and services provided.
2. All patient and family education shall be documented in the Electronic Health Record (EHR)
3. Healthcare providers shall support the provision and coordination of patient education activities and identify and provide the resources necessary for achieving educational objectives.
4. Tri-City Healthcare District (TCHD) shall provide all patients with basic safety related information at the time of admission to Tri-City Medical Center (TCMC).
5. All patient care providers participate in patient education in the course of daily patient care.
6. Patient education is a collaborative process that promotes independence and self-care.
   a. All patients are entitled to information that helps them better understand and cope with their medical condition and treatment plan.
   b. Education enables the patient to resolve health problems, make informed decisions, and institute healthy behaviors.
7. Education provided is based on the patient's assessed needs.
8. The assessment of learning needs addresses age, cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, barriers to communication, literacy, living environment, previous experience and resource availability as appropriate.
9. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following:
   a. Plan for care, treatment, and services
   b. Basic health practices and safety
   c. Safe and effective use of medications
   d. Food-drug interactions

e. Nutrition interventions, modified diets, or oral health
f. Safe and effective use of medical equipment or supplies when provided by the hospital
g. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
h. Rehabilitation techniques to help them reach the maximum independence possible
i. Infection prevention measures
j. Measures taken to help ensure safety in surgery
k. Community resources and when necessary, how to obtain further care, services, or treatment to meet identified needs
l. Appropriate information about patient responsibilities and self-care activities
m. Discharge instructions to the patient and those responsible for providing continuing care
n. Information on oral health
o. Fall reduction strategies

10. Patients receive education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided.
    a. Education is coordinated among the disciplines providing care, treatment, and services.
    b. The content is presented in an understandable manner.
    c. Teaching methods include verbal discussion, written materials, electronic care notes, demonstration and videos.
    d. Teaching methods accommodate various learning styles and readiness to learn
    e. Patient education is documented in the EHR
        i. Assessment of learning needs
        ii. Interventions to meet those needs
        iii. Patient response to education
        iv. Educational materials provided
    f. Comprehension is evaluated and documented
11. Patients receive education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**09/20**	**SUBJECT:**	**Research Activities: Investigational Medications**
REVISION DATE:	**09/20**		

Patient Care Services Content Expert Approval:	~~05/20~~03/23
Clinical Policies & Procedures Committee Approval:	~~05/20~~03/23
Nursing Leadership Approval:	~~06/20~~04/23
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~07/20~~05/23
Medical Executive Committee Approval:	~~08/20~~06/23
Administrative Approval:	~~09/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/20

A. **PURPOSE:**
1. To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in providing for the safe use and dissemination of investigational medications, biologics and devices within the Tri-City Healthcare District (TCHD).
2. To provide guidelines for coordination of medical, nursing, administration, and pharmacy staff in hospital-driven research.

B. **DEFINITION(S):**
1. Clinical Research Site refers to the external organization that is conducting the Clinical Trial or Study.
2. Informed Consent Form (ICF): A document which explains the following:
   a. Details of the study
   b. The potential risks and benefits
   c. Rights and responsibilities
3. Investigational Drugs and Biologics – New drugs or biologics which have been issued an Investigational New Drug (IND) number by the FDA. These medical treatments are for investigational use only
4. Investigational Review Board (IRB): A committee established to review and approve research involving human subjects. The purpose of the IRB is to ensure that all human subject research be conducted in accordance with all federal, institutional, and ethical guidelines. Western IRB is TCHD's IRB of record.
5. Principal Investigator (PI) – Physician(s) with privileges at Tri-City Healthcare District (TCHD) who are responsible for the conduct of the clinical study. In the case of drug studies, the PI would sign the FDA Form 1572 and TCHD would be listed on the Form as a site.
6. Research Subject: All patients enrolled in a clinical trial are referred to by trial personnel as a study subject per FDA guidelines.
7. Research is a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes.
8. Sponsor: An individual, company, institution or organization which takes responsibility for the initiation, management and/or financing of a clinical trial.

C. **POLICY:**

1. All IRB requests are to be made through the TCHD Chief Medical Officer.
2. Clinical trials are administered only in accordance with protocols approved by TCHD.
   a. Investigational drugs, radiation, biologics or devises shall be used only under the supervision of the principal investigator and/or sub-investigator, who assumes the burden of responsibility for the proper conduct of the clinical trial and securing the necessary ICF consent.
   b. The principle or sub-investigator must be a member of the Medical Staff of TCHD for all investigational drug protocols approved by TCHD.
   c. Investigational medications are administered only under the supervision of the authorized investigator and according to protocol. They are to be distributed by the Pharmacy.
3. The IRB and the Pharmacy and Therapeutics (P&T) Committee have oversight over established investigational medication use policies and procedures.
4. TCHD's Director of Pharmacy or designee is responsible for providing information on storage, labeling, distribution and waste. The Director of Pharmacy or designee shall review the Investigational Drug Fact sheet with nursing personnel as requested.
5. If not specified in the protocol, investigational medications are assessed for hazard characteristics to direct safe handling and disposal. If the information provided is deemed insufficient to make an informed decision, the investigational drug is considered hazardous.
6. Verbal orders for a study medication are not acceptable.

D. **PROCEDURE / ROLES AND RESPONSIBILITIES:**

1. The signed ICF is to be placed in the health record.
   a. If there is no consent and the patient does not have one available, the RN or Healthcare provider needs to call the clinical trial site to obtain a copy.
   b. No procedures or trial-related medications may be administered until this consent is on file in the health record.
2. Prior to the initiation of the clinical research study, sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.
3. Copies of the orders are to be provided to lab and radiology when appropriate.
4. Sponsor:
   a. Provides information on storage, labeling, and distribution to pharmacy
5. Principal Investigator:
   a. Provides a nursing summary and drug fact sheet to the nursing in one-page outlines. The information provided shall include:
      i. Dosage form
      ii. Route of administration
      iii. Strength
      iv. Actions
      v. Uses
      vi. Side effects
      vii. Adverse effects
      viii. Interactions
      ix. Symptoms of toxicity
      ~~ix.~~**x. Acceptable rescue medications for an adverse drug reaction**
   b. Obtains fully executed ICF and places a copy in the health record.
   c. Upon study initiation, the PI shall provide a written order to the Pharmacy.
      i. If oral study medication has been provided to study subject they may take their own study drug.
      ii. An order from the PI for the oral drug can be provided by the site or Pharmacy.
6. Pharmacist:
   a. Review the Investigational Drug fact sheet with nursing personnel as requested.
   b. Process all investigational medications

i. The TCHD Pharmacy address must be listed as the receiving party for all investigational drug study medications.

ii. Study drug distributor/Sponsor must notify pharmacy as to expected date of receipt, and every attempt must be made by distributor to deliver during normal business hours.

iii. Once received in the pharmacy, investigational study medications shall be inspected for damage, quantity verified, documented on the study master accountability form, and stored at appropriate temperature by the pharmacist or delegated pharmacist trained on the study.

iv. Investigational study medications shall be stored in a separate locked ~~room~~ **storage area** within the pharmacy, accessible only to pharmacists and other pharmacy personnel under the supervision of a pharmacist.

1) Temperature logs shall be maintained in this room for drugs stored under ambient and refrigerated conditions per Pharmacy Procedure: Patient Medication Refrigerators.

v. An inventory record shall be kept on each investigational drug. A record shall be kept for each dose of investigational drug dispensed.

vi. Inventory of investigational drugs shall be kept and include the following:

1) Quantities dispensed
2) Identities of patients
3) Quantities of medications returned, lost, or destroyed

vii. Clinical trial materials and/or investigational drugs shall be returned or destroyed per protocol and sponsor direction.

viii. Information on current Drug and Study Protocols is maintained in the Pharmacy. Information on closed studies is maintained in the Pharmacy for a period of at least one year following the study close-out. After one year, the information may be moved to on-site storage for at least another year before transfer to off-site storage. All study documentations are to be ~~kept permanently.~~**retained for at least two years after completion of the research. Records may need to be kept longer if specified by the sponsor.**

c. Dispenses Investigational drugs (TCHD licensed pharmacist only)

i. All investigational drugs shall be properly labeled, with auxiliary labeling if necessary:

1) Name of drug or identification of investigational protocol.
2) Strength
3) Expiration date of the drug. If no expiration date is available, a re-test date shall be used as the expiration date. In the event that an expiration or re-test date is not available, a memo from the sponsor shall be obtained stating that they assume responsibility for notifying the pharmacy prior to the drugs expiration date.
4) Expired or damaged medications are isolated from all other study medications. These medications are not placed into storage with non-study medications

ii. For intravenous investigational agents the following process shall be followed:

1) A pharmacist~~, or intravenous (IV) room pharmacist,~~ shall prepare or directly supervise preparation of all IV investigational infusions.

~~2) For any IV doses not dispensed during the IV room pharmacist shift, communication will be made to the evening pharmacist of any pending investigational infusions.~~

~~3)~~**2)** IV infusions for investigational drugs should be infused via a separate site and clearly labeled as "Investigational Drug" whenever possible. If IV infusions for investigational drugs are infused into a line with other medications, the line must be flushed with normal saline, or flushed per study protocol if specified by the sponsor.

iii. For studies without a study-specific transportation log, a TCHD electronically monitored dispensing/transportation log shall be completed whenever investigational medications are delivered by pharmacy personnel to nursing units. ~~The pharmacy personnel and receiving nurse will sign the log.~~

iv. Procedures pertaining to the disposition of any remaining study drug or study drug preparation shall be determined prior to patient enrollment.

1) Medications not used by the patient shall be returned to the pharmacy or may be retained by the patient per physician's order.

2) When the protocol is closed, the medications shall be returned to the sponsor, physician, or destroyed through standard hospital procedure, as directed by the sponsor or PI.

d. All pharmacists involved in investigational drug dispensation must complete training by the Director of Pharmacy or designee and sign-off that they have received training.

i. Training and delegation logs shall be maintained in the pharmacy study binder.

ii. **~~Curriculum Vitae~~** ~~(CV)'s and~~ California pharmacist license shall be maintained in the pharmacy study binder if required by the sponsor.

iii. Staff education is provided in the departments and to the staff involved.

e. Two pharmacists check the final prepared study medication prior to dispensing. In the event that two pharmacists are not available, a pharmacist and another licensed clinician perform the final check.

7. Study Coordinator:

a. Provides an in-service to nursing when all items are finalized.

b. Study requirement checklist must be completed by the PI or research coordinator prior to enrollment of patients.

c. Staff education is provided in the departments and to the staff involved.

i. Pharmacists involved in study drug dispensing or monitoring shall be educated on study procedures. This shall include:

1) Documentation

2) Monitoring (if required by the study)

3) Randomization (when pharmacy is the responsible party)

4) Blinding

5) Proper storage, preparation, and dispensing of the study drug.

8. Nursing:

a. Reviews orders, the nursing summary, and drug fact sheets

b. Coordinates distribution of the information and in-service education to the nursing staff.

9. Registered Nurse administering medication(s):

a. Verifies informed consent.

i. A copy of the consent is retained in the IDS pharmacy and health record

b. Reviews the Pre-Printed Order (PPO), drug fact sheet and nursing summary

c. **For intravenous investigational agents,** ~~A~~administers IV infusions for investigational drugs via a separate site and clearly labeled as "Investigational Drug"

i. Investigational drugs can only be infused into a line with other medications with approval from the PI and **a p**~~P~~harmacist.

E. **DOCUMENTATION:**

1. Documentation in the health record shall include:

a. Signed copy of informed consent

b. Physician's order for the investigational drug including:

i. Name

ii. Dose

iii. Route

iv. Duration of administration (included on the PPO)

v. Frequency of administration

vi. Acceptable rescue medications for an adverse drug reaction

c. Order for disposition of any unused medication
d. Completed Medication Administration Record (MAR)
e. All side effects and adverse reactions to the investigational drug shall be noted in the nursing notes and reported to the physician.
f. Results for all tests ordered at TCHD as part of the research protocol

F. **PATIENTS ENTERING TCHD WHO ARE PARTICIPATING IN AN OUTSIDE CLINICAL TRIAL:**

1. For patients entering TCHD who are in an outside clinical trial (not recognized or approved by the TCHD-), the pharmacy shall adhere to the following guidelines:
   a. The PI shall be notified and evaluate the appropriateness of the patient's continuance in the investigational study.
      i. If no contraindication exists, the investigational study medications may be continued during hospitalization.
      ii. If the PI does not have privileges at TCHD this information must be communicated to the admitting physician or hospitalist assuming care of the patient.
   b. The admitting physician or Allied Health Professional (AHP) shall provide a written order for "patient may take own study drug" or similar wording.
   c. ~~A~~The ~~IDS~~ pharmacist shall verify identity and confirm the study drug.
   d. The PI shall complete the Investigational Drug Fact Sheet for nursing and pharmacy.
   e. The TCHD SRC and pharmacy shall accept a copy of the original informed consent
      i. A copy shall be placed on the patient's medical chart
   f. Sufficient education is provided to the pharmacy and nursing staff charged with dispensing and administering the medication.

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

1. Pharmacy Procedure: Patient Medication Refrigerators

H. **REFERENCE(S):**

1. https://www.fda.gov/regulatory-information/search-fda-guidance-documents/clinical-trials-guidance-documents
2. https://support.nlm.nih.gov/knowledgebase/category/?id=CAT-01242
3. ~~http://wirb.com/Pages/default.aspx~~ **https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?fr=312.57**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Spiritual Care of the Patient

REVISION DATE: 06/03, 01/04, 04/06, 08/08, 04/11 04/15, 08/20

Patient Care Services Content Expert:	~~06/20~~05/23
Clinical Policies & Procedures Committee Approval:	~~07/20~~06/23
Nursing Leadership Approval:	~~08/20~~08/23
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~08/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **POLICY:**

1. Healthcare providers may not impose their own values on patients, nor may they represent themselves as spiritual advisers, but may interact in a non-judgmental and supportive way as patients express their spiritual concerns.
2. When appropriate, healthcare providers advise the patient or family of spiritual services available (i.e., the hospital chaplain, other members of the religious community).
   a. If the patient or family wishes, healthcare providers may call a member of the clergy to visit the patient or family.
3. The social worker and hospital chaplain may work together when responding to the emotional and spiritual needs of patients and families.
4. The primary service and activity of the chaplains is to meet with the patients, their families, and healthcare providers.
5. The Pastoral Care Department may be utilized at any time by patients, families, or staff. The chaplains are present in the hospital ~~from 8:00am – 4:00 pm~~, Monday through Friday and may be reached through the operator. At all other times a chaplain is on-call for emergencies and may be contacted through the Administrative Supervisor.
6. The chaplaincy staff shall assist in arranging sacraments and religious rites for patients in accordance with the patient's denominational and religious traditions.
7. The ~~professional~~ staff shall facilitate support by the patient's/family's personal clergy if requested. All local clergy are welcomed and **can request** assist**anceed through**~~in~~ the Pastoral Care office.
8. Requests for Pastoral Care visitation and reception of the sacraments shall be documented in the medical record.
9. Pastoral counseling is available for patients, faculty, and staff by making a referral or appointment with one of the chaplains.
10. ~~Trained Pastoral Care volunteers shall visit patients on a regular basis.~~
11. **10.** The chapel is available to all faiths for prayer and quiet time.
12. **11.** If the parents of critically ill infants or deceased infant have any faith-based practice they wish for the infant such as being blessed or baptism, healthcare providers should attempt to honor this request.
    a. Attempt to reach appropriate clergy if the family has not already done so.
    b. If clergy is unavailable, or per parent(s) request a bereavement support staff or any member of the medical or nursing staff may perform an emergency blessing or baptism.
       i. It is preferable, but not necessary, for the person performing the blessing or baptism to be of the same denomination as the family.

1. Pour a small amount of sterile water three times, saying: "I bless or baptize you in the name of the Father, and of the Son, and of the Holy Spirit."

ii. If infant has been named, use the full given name in place of "you".

iii. If possible, another staff member should witness the blessing or baptism.

c. Document in the medical record and on the Checklist for Assisting Parent(s) Experiencing Neonatal Death/Stillborn that blessing or baptism was performed with date, time, and name of person who performed the blessing or baptism.

B. **REFERENCE(S):**

1. Walter, M.A., Limbo, R., Wilke, J. (**2017**~~2015~~). *Resolve Through Sharing: Bereavement Training: Perinatal Death.* La Cross, Wisconsin. Gunderson Lutheran.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ULTRASOUND GUIDED PERIPHERAL INTRAVENOUS (IV) ACCESS**
Purpose:	To outline the process of insertion of peripheral IV catheters with ultrasound guidance by appropriately trained and competent Registered Nurses
Supportive Data:	See References
Equipment:	1. IV supplies per standard peripheral IV protocol. Note: A longer length of catheter may be needed. 2. Portable Ultrasound machine 3. Probe cover 4. Sterile water based gel 5. Local anesthetic (optional)
Issue Date:	02/16

A. **POLICY:**

1. Ultrasound is an aid to placement of a peripheral intravascular venous (IV) access.
   a. Appropriate patient and site selection using ultrasound remains the same as the traditional landmark approach.
2. To be used for those patients with difficult access (more than two unsuccessful attempts), or those with anticipated difficult access (patients with obesity, edema, hypovolemia, or history of repeated venipuncture).

B. **PROCEDURE:**

1. Insertion
   a. Place tourniquet
   b. Perform preliminary ultrasound scan to find preferred site and adjust machine settings
   c. Release tourniquet
   d. Prepare the probe with application of a small amount of gel then apply probe cover.
   e. Scrub area of insertion (about 3 inches in diameter from selected site) with chlorhexidine.
   f. Reapply tourniquet
   g. Apply sterile gel distal to the site of insertion
   h. Apply the probe onto the gel and slide proximally while identifying the vein. Attempt to maintain sterility of the catheter and prepared site. The insertion site should be dry and free of gel.
   ~~i. Inject 1% lidocaine without epinephrine (local anesthetic) under skin at point of catheter puncture site as needed if ordered by physician (optional step)~~
   ~~j.~~**i.** Insert catheter per Online Skills Intravenous Therapy: Initiation.
   ~~k.~~**j.** Apply dressing per standard peripheral IV protocol.
2. Documentation
   a. Document insertion of peripheral IV in the I**view**~~VIEW~~ Peripheral IV section.
   b. Document use of ultrasound for IV placement, catheter size, length, location And site condition.

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

1. Online Intravenous Therapy: Initiation

D. **REFERENCE(S):**

1. Constantino, T et al. Ultrasonography-Guided Peripheral Intravenous Access Versus Traditional Approaches in Patients With Difficult Intravenous Access. *Annals of Emergency Medicine 2005, 46(5):456-461.*

Department Review	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/15, 11/19, **01/23**	09/15, 12/19, **02/23**	09/15, 02/20, **03/23**	n/a	11/15, 03/20, **05/23**	01/16, 04/20, **06/23**	05/20, **08/23**	02/16, n/a	02/16, 05/20

2. Doniger, S et al. Randomized Controlled Trial of Ultrasound-Guided Peripheral Intravenous Catheter Placement Versus Traditional Techniques in Difficult Access Pediatric Patients. *Pediatric Emergency Care 2009, 25(3)154-159.*
3. Miles, G et al. Implementation of a Successful Registered Nurse Peripheral Ultrasound-Guided Intravenous Catheter Program in an Emergency Department. *Journal of Emergency Nursing 2012; 38(4):353-356.*
4. White, A et al, Developing and Sustaining an Ultrasound-Guided Peripheral Intravenous Access Program for Emergency Nurses. *Advanced Emergency Nursing Journal 2010, 32(2):172-188.*

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/99	**SUBJECT:** ~~Unidentified or~~ Confidential Patient
REVISION DATE: 05/03; 04/06; 04/09, 04/15, 10/19	**POLICY NUMBER:** 8610-374

Patient Care Services Content Expert Approval:	~~07/19~~05/23
Clinical Policies & Procedures Committee Approval:	~~09/19~~06/23
Nursinge Leadership~~Executive Committee~~ Approval:	~~09/19~~08/23
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Administration Approval:	~~10/19~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/19

A. **PURPOSE:**

1. To ~~identify a patient in a timely manner in order to treat a patient in an emergent situation or~~ to protect a patient's safety if his/her location were known.

B. **POLICY:**

~~1. Criteria for creating unidentified patient (Jane/John Doe):~~

~~a. Register the patient in Cerner using "John Doe or Jane Doe".~~

~~b. Update demographic information in both Cerner and Affinity as it becomes available.~~

~~2.~~**1.** Criteria for creating a confidential patient:

a. Tri-City Medical Center (TCMC) staff have identified patient as a possible victim of violence, or other situation where the patient's life is in danger, if his/her location was known.

b. Admitting/Registration will register patient as "John Doe" or "Jane Doe" **per Administrative Policy: Assignment of Medical Record Numbers and Standard Naming Guidelines** ~~using all of the patients' correct information except for name.~~

~~i. If the patient has been to TCMC in the past, notify the units' Assistant Nurse Manager (ANM)/designee/relief charge of the patient's correct Medical Record Number.~~

c. Notify Security, Risk Management and Social Services.

~~ii.~~**d.** When it is determined that a security risk no longer applies the unit **Nurse Leader**~~ANM/~~ designee~~/relief charge~~ will contact Registration to make the necessary edits to the patient's name.

~~iii.~~**i.** Change name of the patient only after patient is no longer a security risk.

~~c.~~**2.** If a patient would like to be considered "confidential" for reasons other than safety they must **notify the staff of the their request**~~access~~ **(see** Administrative Policy:~~ # 526,~~ Right to Request Privacy Restriction for Protected Health Information **526).**

C. **RELATED DOCUMENTS:**

1. Administrative Policy: Assignment of Medical Record Numbers and Standard Naming Guidelines 390

~~1.~~**2.** Administrative Policy: Disclosure of Information to Public and Media 524

~~2.~~**3.** Administrative Policy: Right to Privacy Restriction for Protected Health Information 526

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**VENTRICULAR ASSIST DEVICE: IMPELLA NURSING CARE OF THE PATIENT**
Purpose:	To provide guidelines for the safe nursing care and monitoring of the patient with an Impella device in place outside of the Cath Lab (CCL) or Operating Room (OR).
Supportive Data:	ABIOMED Impella Protocol and Tools
Equipment:	Impella_2.5/CP_5.0/LD_RP/**5.5**

A. **DEFINITION(S):**

1. Left Sided Impella: Impella ~~2.5~~,CP,~~5.0/LD~~/**5.5**
   a. The Impella ~~2.5~~/CP/~~5.0~~/**5.5** are percutaneously inserted temporary ventricular assist devices (VAD) which provide hemodynamic support by using a small microaxial blood pump housed inside a catheter to pull blood from the left ventricle into the aorta, unloading up to five **and a half** liters of blood. This action effectively decreases left ventricular preload, increases mean arterial pressure and forward flow, increases end-organ perfusion and protects the myocardium by decreasing oxygen demand and increasing oxygen supply. They are recommended for short-term use ~~(Impella 2.5 and~~ Impella CP < 4 days, ~~and Impella 5.0 <6 days~~, **Impella 5.5 less than (<) 14 days** or per MD order)
   ~~b. Impella 2.5 is inserted percutaneously via an introducer sheath and is capable of unloading up to 2.5 liters of blood per minute.~~
   ~~c.~~**b.** Impella CP is inserted percutaneously via an introducer sheath and is capable of unloading ~~2.5~~-3.5 liters of blood.
   ~~Impella 5.0/LD assist device is inserted peripherally via arterial cut down and is capable of unloading up to 5.0 liters of blood per minute.~~
   ~~d.~~**c. Impella 5.5 is inserted via surgical cut-down through the axillary artery or direct Aorta and into the left ventricle and is capable of unloading up to 5.5~~2.2~~ liters of blood.**
2. Right Sided Impella: Impella RP System
   a. The Impella RP System is a percutaneously inserted temporary ventricular assist device (VAD) with an intracardiac microaxial blood pump that supports a patient's pulmonary circulation. It is inserted percutaneously through the femoral vein and into the pulmonary artery (PA). It delivers blood from the inlet area which sits in the inferior vena cava (IVC), through the cannula, to the outlet in the pulmonary artery. **It is recommended for short term use less than (<)14 days.**

B. **POLICY:**

1. The Impella device will be placed in the Cardiac Catheterization Lab (CCL) or Operating Room (OR) and may or may not be removed prior to leaving the CCL or OR.
2. The patient with an Impella device in place outside of CCL or OR must be cared for in the Intensive Care Unit (ICU) by an Impella-trained Registered Nurse (RN).
3. Nurse to patient ratio will be at least 1:1
4. Left Sided Impella: Impella ~~2.5~~,CP,~~5.0/LD~~/**5.5**
   a. The Left-sided Impella device provides left heart support. Monitor patient for signs of right heart failure and assess need for bi-ventricular implantable cardiac defibrillator (BIVICD) if necessary. Signs of right heart failure may include:
      i. Reduced output from Impella.
      ii. Suction alarms on Impella console.
      iii. Elevated CVP.
      iv. Signs of liver failure

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/18, 09/21, **03/23**	12/18, 06/22, **03/23**	12/18, 07/22, **04/23**	11/18, 08/22	01/19, 10/22, **05/23**	02/19, 11/22, **06/23**	03/19, 12/22, **08/23**	n/a	03/19, 12/22

v. Elevated PA pressures.

b. Indications:
   i. Stable patients with high-risk coronary disease scheduled for revascularization.
   ii. Cardiogenic shock patients in need of left ventricular support.
   iii. Patients with reduced ventricular function, e.g., post-cardiotomy, low output syndrome, post-MI, and peri/post percutaneous coronary intervention (PCI).

c. Contraindications:
   i. Mural Thrombus in the left ventricle
   ii. Presence of mechanical aortic valve or heart constrictive device
   iii. Aortic valve stenosis/calcification (equivalent to an orifice area of $0.6cm^2$ or less)
   iv. Moderate to severe aortic insufficiency (echocardiographic assessment graded as **greater than or equal to** (≥) +2)
   v. Severe peripheral arterial disease precluding placement of the Impella system
   vi. Significant right heart failure
   vii. Combined cardiorespiratory failure
   viii. Presence of an atrial or ventricular septal defect (including post-infarct VSD)
   ix. Significant right heart failure (Cardiogenic shock and COVID-19 emergency use authorization (EUA) indication)
   ~~ix.~~**x.** Left ventricular rupture **(Cardiogenic shock and COVID-19 EUA indication)**
   xi. Cardiac Tamponade **(Cardiogenic shock and COVID-19 EUA indication)**~~(Cardiogenic shock indication only)~~
   ~~x.~~**xii. Combined cardiorespiratory failure (Cardiogenic shock indication only)**

5. Right-Sided Impella - Impella RP
   a. Indications:
      i. The Right-Sided Impella device provides right heart support for patients such as those who develop acute right heart failure or decompensation following left ventricular assist device implantation, myocardial infarction, heart transplant or open-heart surgery.
   b. Contraindications:
      i. Disorders of the pulmonary artery wall that would preclude placement or correct positioning of the Impella RP device
      ii. Mechanical valves
      iii. Severe valvular stenosis or regurgitation of the tricuspid valve (TV) or pulmonary valve (PV)
      iv. Mural thrombus of the right atrium (RA) or vena cava
      v. Anatomic conditions precluding insertion of the pump
      vi. Presence of a vena cava filter or caval interruption device.

C. **PROCEDURE:**

1. General considerations:
   a. Ensure the Impella console is always plugged in; device can function for one hour without AC power. It may take up to ~~10~~ **5** hours to fully re-charge the Impella.
   b. Do not raise HOB greater than 30 degrees if patient is temporally cannulated **for femoral access. Obtain physician orders Axillary or Direct Aortic access (Impella 5.5)**
   c. Obtain order for knee immobilizer if patient is unable to maintain straight-leg position and is femorally cannulated.
   d. Perform dressing changes to insertion site per hospital policy or as needed (PRN) using aseptic technique and transparent dressing.
   e. Refer to the infection prevention guidelines in relation to hand hygiene and possible person protection equipment (PPE) when applicable.
   f. Assess insertion site every one hour for bleeding, hematoma or infection.
   g. Monitor pedal pulses every 15 minutes times 4, every 30 minutes times 4, then assess for limb ischemia every one hour.

h. Turn patient according to implanting cardiologist/cardiac surgeon's order. Patient positioning order must be reviewed daily with implanting cardiologist/cardiac surgeon.
i. Use care when turning, repositioning, or performing bed-to-gurney or bed-to-bed transfers to ensure the device is not pulled on or pulled out.
j. Do not allow red Impella plug (left-sided Impella) or blue Impella plug (right- sided Impella) to hang freely from catheter and avoid bending catheter near red (or blue) Impella plug to avoid kinking.
k. Impella may cause ECG interference. Set bedside monitor to "filter" status for ECG interference.
l. Patient ~~will be~~**may or may not be** anticoagulated with a heparin/**dextrose** infusion. Monitor PTT per physician orders for Pharmacy to dose **if ordered**.
m. Obtain daily transthoracic echocardiogramy or portable chest X-ray to determine Impella catheter placement per physician order. Implanting cardiologist/cardiac surgeon to review Impella catheter placement daily with the nurse.
n. The catheter of the Impella ~~2.5,~~ CP, ~~5.0/LD~~, ~~and~~ RP**, and 5.5** is to be removed only by a Physician or Physician Assistant.
o. The performance level indicates the performance level at which the catheter is operating (how much it is unloading) and is determined by physician order and is set to achieve desired hemodynamics.
p. If the patient with an Impella device in place needs CPR, place performance level at "P2" and perform CPR with device in place and running.
~~q. Change NS arterial flush/tubing daily for 2.5~~ **and** ~~and CP devices. For 5.0/LD, or RP~~ **or 5.5** ~~device no arterial flush is required.~~
~~r.~~**q.** Purge fluid and purge tubing change per hospital's protocol on fluid and tubing change.
~~s.~~**r.** Wean per physician orders.

2. On Admission to critical care:
   a. Order echocardiogram (left-sided Impella) or Chest X-ray (right-sided Impella) to verify placement on arrival to critical care unit as soon as possible.
   b. Verify that Tuohy-Borst valve on Impella catheter is locked to prevent catheter migration. **(Impella CP and RP). Impella 5.5 has updated auto lock**
   c. Switch to P-level mode and ~~disable P-level suction control.~~ **disable auto mode**
   ~~d. If the purge system has not been transferred to the standard configuration, follow the steps below:~~
      ~~i. Press "PURGE SYSTEM" to select "Transfer to Standard Configuration" from the menu.~~
      ~~ii. Do not use saline. Use Heparin/Dextrose purge solution as ordered by the physician~~
      ~~iii. Select OK to deliver a bolus to the pressure reservoir so that the reservoir can maintain purge pressure during the change. A progress bar shows the progress of the bolus. After the bolus is delivered, the controller automatically proceeds to the next screen.~~
      ~~iv. Disconnect the yellow luer from the Impella catheter and remove the used purge cassette.~~
      ~~v. Insert the new purge cassette into the controller. Be sure to slide the purge pressure transmitter into place and extend the purge tubing through the gap in the purge cassette door when you close the door.~~
      ~~vi. The system automatically primes the purge cassette. A progress bar shows the progress of the priming. Once the priming is complete, you are prompted to connect the purge tubing to the Impella catheter.~~
      ~~vii. Connect the yellow luer on the end of the purge tubing to the yellow luer on the Impella catheter.~~
      ~~viii. Purge system change is complete. Enter the purge fluid information and select~~

~~OK.~~

~~1) To select the default purge fluid values displayed on the screen, scroll to and select OK. This will select those values and automatically advance to the next screen.~~

~~2) To change the purge fluid information, scroll to the appropriate item and push the selector knob to select it. Then scroll through the values and push the selector knob to make a new selection.~~

~~e.~~**d.** Assess and chart the centimeter marker on the Impella catheter closest to the sheath.

~~f. Ensure roller clamp is completely open on the line to the pressure bag.~~

~~g. Verify that the pressure bag is inflated to 300-350 mmHg.~~

~~h.~~**e.** It is recommended that central venous pressure (CVP) be monitored and that a level of 12 mmHg be maintained, **n the setting of suction or hemolysis**

3. Monitoring of catheter position:
   a. The position of the Impella device is monitored by the RN continuously via placement signal and motor current displays and the placement monitoring illustration display on the Impella console.
   b. Obtain physician order for daily transthoracic echocardiography or portable chest x-ray to monitor position.
   c. The ideal position of the Impella catheter is:
      i. For Impella ~~2.5~~,CP, ~~5.0/LD~~**/5.5**, the catheter inlet lies in the left ventricle and the catheter outlet in the aorta, the placement signal and motor current displays will be pulsatile and the Impella catheter icon will be displayed with the valve symbol in the middle of the catheter. **Visible on the home screen.**
      ii. For Impella RP, the catheter inlet lies in the inferior vena cava (at the level of the diaphragm or apex of the heart away from RA and TV) and the catheter outlet in the PA (bifurcation of the right and left PA branch), the placement signal and motor current displays will be similar to a PA waveform.
   d. Note and document catheter position markings after placement and hourly.
   e. Ensure device is secured to leg with tape.
   f. If the device migrates, the following warnings will appear on the Impella console: "Impella position wrong" or "Impella **position** in Ventricle" **or** "**Impella position in Aorta**"
      i. If the pump console alarms that the device is not positioned properly, reduce performance level to "P2" and notify the physician immediately- only a physician may reposition the device. The physician may request echocardiography or fluoroscopy for guidance.
   g. Low native heart pulsatility: In a patient with poor native ventricular function, the placement signal may remain pulsatile. However, the amplitude will be dampened.
   h. If the device is out of position, the patient may be at risk for hemolysis. Monitor the patient for and notify physician of signs of hemolysis including:
      i. Decreased hemoglobin level.
      ii. Dark or blood-colored urine.
      iii. Acute renal failure.

~~i. For "Placement Signal Lumen Blocked" alarm~~

~~i. Ensure roller clamp on pressure bag is fully open~~

~~ii. Check pressure in the pressure bag (300-350mmHg)~~

~~iii. Close roller clamp and disconnect IV from the red luer, do not grip the white flush valve when trying to disconnect IV from luer~~

~~iv. Attach 20 cc syringe to red luer, squeeze white flush valve, and aspirate 1-2 cc of blood into syringe~~

~~v. Remove syringe and open roller clamp~~

~~vi. Hold the clear luer upright and flood with saline from the pressurized bag~~

~~vii. Reconnect IV to the red luer and ensure roller clamp is still open~~

~~viii. Squeeze or pinch white flush valve side-to-side and flush the aspirated blood from the lumen~~
~~ix. If still unable to get placement signal, notify MD and utilize motor current waveform to ensure positioning across the aortic valve.~~

~~4. Normal saline (NS) arterial flush solution (2.5 **and** and CP devices only):~~
~~a. Change flush solution daily and prn~~
~~b. Perform hand hygiene and don gloves.~~
~~c. Prime the new NS flush solution set-up and close the roller clamp.~~
~~d. Place the NS bag in a pressure bag and inflate to between 350-400 mmHg.~~
~~e. Close the roller clamp and disconnect the old flush solution connected at the red sidearm port.~~
~~f. Open the roller clamp on the new flush solution set-up to start a slow drip.~~
~~g. Position the male luer connector over the female luer connector and fill to overflow, displacing any air.~~
~~h. Connect and secure luer fittings.~~
~~i. Open the roller clamp all the way and squeeze the white wings for 5 to 10 seconds to complete the internal prime- the final prime should eliminate any risk of lost or dampened pressure caused by blood tracking into the pressure lumen during the pressure tubing change.~~
~~j. To maintain a good pressure signal: periodically fast-flush catheter lumen for 15-20 seconds, maintain pressure bag at 350-400 mmHg.~~
~~k.~~**i.** ~~Remove gloves and perform hand hygiene.~~

~~5.~~**4.** Suction Alarm:
a. Suction alarm may occur if the circulating blood volume is inadequate or if blood return is restricted.
b. Suction will limit the amount of support the device can provide and will result in decreased blood pressure, cardiac output, and dysrhythmia.
c. Suction can cause hemolysis by damaging the red blood cells.
d. Suction can be caused by:
    i. Left-sided Impella:
        1) Right ventricular failure - consider RV support
        2) Improper catheter position - check catheter position
        3) Hypovolemia - correct volume deficits
    ii. Right-sided Impella
        1) Inadequate preload - correct volume deficits
        2) Malposition - check device position (Chest X-ray, fluoroscopy, or echo)
e. Assess for and correct the above conditions if a suction alarm occurs.
f. While running in auto-mode if the controller detects suction it will alarm "Impella Flow Reduced" and will automatically reduce motor speed to reduce the flow rate.
g. While running in P-Level mode, if the controller detects suction it will alarm "Suction".
h. Recommended actions:
    i. Impella ~~2.5~~/CP:
        1) Check the device position
        2) Confirm RV function by assessing CVP or right side function with echocardiography or fluoroscopy. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
        3) Assess patient's fluid intake and output to confirm adequate volume status.
        4) Return P-level to pre-alarm setting.
    ii. Impella ~~5.0/LD~~**/5.5** Catheter:
        1) Reduce P-level by 1 or 2 levels to reduce the effects of suction.
        2) Check the device position

3) Assess patient's fluid intake and output to confirm adequate volume status.
4) Check the Impella Catheter for correct positioning using imaging. Reposition the catheter by rotating or moving it into or out of the ventricle slightly. Either or both of these actions could help move the inlet of the Impella Catheter away from the interior ventricular wall.
~~4)~~**5)** Confirm RV function by assessing CVP or right side function with echocardiography. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
~~5)~~**6)** Return the P-level to pre-alarm setting Q.

iii. Impella RP:
1) If suction is an issue, the flow displayed on the controller maybe higher than the actual Impella RP flow rate.
2) If the suction alarm appears on the controller when the Impella RP is running at P-levels between P7 and P9, decrease the P-level to P6, or to P5, or to P4 as needed, to resolve suction. If suction alarm continues when P- level is between P4 and P6, momentarily stop the Impella RP to resolve the suction issue and then restart it immediately.
3) Evaluate patient volume status; maintain a positive CVP
4) Check device position
5) Return to previous P-level when suction alarm is resolved when appropriate

~~6.~~**5.** Differential pressure sensor:
a. Impella ~~2.5 &~~ CP / **5.5**
i. Not Applicable
b. Impella ~~5.0/LD, or~~ RP ~~**or 5.5**~~
i. The Impella ~~5.0LD,~~ RP has an electronic differential pressure sensor at the proximal end of the cannula which generates the placement signal, the placement signal is equal to the difference. The sensor generates an electrical signal proportional to the difference between the pressure outside the inlet area and the pressure inside the cannula. This signal is displayed on the Automated Impella Controller as the placement signal.
ii. If the waveform shifts up or down on the y-axis or if the flow rate does not match the performance level setting, the differential pressure sensor is experiencing "drift" and may require zeroing.
1) Press the MENU key and select "Start Manual Zero."
2) Select OK to confirm the decrease in P-level ~~3~~.
3) The controller displays "Wait until the new P-level is reached" and then "Calculation is running".
4) Select OK to accept the new setting when the controller displays the "Placement Signal Offset Adjust finished!" message.
5) The Impella will automatically be reset to the previous P- level.

~~7.~~**6.** Purge pressure management:
a. The purge system prevents blood from entering the microaxial motor by providing a pressure barrier via the flow of purge fluid through the motor in the opposite direction of the blood flow.
b. Purge pressure must be greater than the patient's peak blood pressure.
c. Increasing the flow of the purge fluid will increase the purge pressure, decreasing the flow of purge fluid will decrease the purge pressure**, the Impella can not be titrated, it is self regulating.**
d. The AIC console that accompanies the Impella device is used to adjust the purge fluid flow rate.
e. Purge pressure is displayed on the Impella console.

f. Purge fluid flow rate is not to be less than 2 mL/hour or greater than 30 ml/hour.
g. Purge fluid and purge tubing change per hospital policy
   i. Perform hand hygiene and don gloves.
   ii. Open PURGE SYSTEM menu and select "Change Purge Cassette"
   iii. Follow the instructions on the screen to change the purge cassette.
h. Standard Purge Solution: **Heparin/Dextrose or Sodium Bicarbonate/Dextrose based solution will be ordered by the physician and provided by the pharmacy. The concentration of the purge fluid may be adjusted per physician request.** ~~The Heparin/Dextrose solution provided by the pharmacy is Heparin 25,000 units in Dextrose 5%, 500 ml (concentration 50units/ml) and is for intra-arterial flush. The amount of heparin and dextrose in purge fluid may be changed per physician order.~~
   Note: for Impella RP, the Heparin/Dextrose solution is started in Cardiovascular Lab rather than in the critical care unit.
i. "Low Purge Pressure" alarm (purge pressure less than 300 mmHg and purge flow greater than or equal to 30 mL/hr.:
   i. Check for leaks and loose connections in or on the purge cassette, yellow luer connection to the clear sidearm, the clear sidearm and the red luer connection (if the Y connector is being used)
   ii. Change purge cassette if leaking or every 72 hours.
   iii. If there are no leaks, change to a purge fluid with a higher dextrose concentration. To do this, open the Purge System menu and select "Change Purge Fluid." Follow the instructions on the screen.
   iv. If the pressure stabilizes, no other action is required.
   v. If the purge pressure is not stable and the low purge pressure alarm remains unresolved for more than 20 minutes, there may be a problem with the purge cassette. Replace the purge cassette. (Follow the instructions on the screen "Change Purge Cassette")
   vi. If the low purge pressure alarm still remains unresolved for more than 20 minutes, this may be a sign of Impella catheter damage. Inform MD.
j. High purge pressure will result in one of two alarms- "Purge Flow Low" or "Purge System Blocked"
k. For high purge pressure (purge pressure greater than or equal to 1100 mmHg and purge flow less than 2 ml/hour):
   i. Check for kinks in the purge tubing, clear sidearm, catheter shaft and Y connector (if being used)
   ii. Ensure plastic clip on pressure reservoir of the clear sidearm is snapped into connector cable
   iii. Decrease dextrose concentration (must obtain physician order)
   iv. Monitor motor currents and note any upward trend, consider replacing catheter if a rise in motor current is seen.
l. For in-depth troubleshooting of purge pressure alarms, refer to Impella user manual located on the unit.

D. **DOCUMENTATION AND ASSESSMENT:**

1. In electronic health record (EHR) document:
   a. Vital signs per standards of care.
   b. Intake and output (I&O) every hour.
   c. Daily weights.
   d. Positioning/repositioning as ordered.
   e. Dressing change per hospital policy.
   f. Head of bed elevation hourly.
   g. If femorally cannulated, assessment of pulses and signs of limb ischemia hourly.
   h. If femorally cannulated, perform neurovascular checks of the extremity with the Impella device every hour and prn Notify the physician immediately if signs and

symptoms are present (6Ps - pain, pallor, paresthesia, paralysis, pulselessness, poikilothermia).

i. Subjective patient complaints:
   i. Deep throbbing feeling of pressure in affected extremity.
   ii. Calf pain with dorsal flexion of foot (Homan's sign).
   iii. Loss of lower leg sensation or function.
j. Objective finding (for unconscious patient or patient unable to communicate):
   i. Ankle/arm index: Ankle systolic divided by brachial systolic, (radial/brachial arterial line systolic okay).
   ii. Normal ankle/arm index value = 0.8 - 1.2.
   iii. Post insertion ankle/arm index < 0.8 have 8 times the risk of limb ischemia.
k. Assessment of access site hourly.
l. Monitor and document upon arrival, every hour and with repositioning:
   i. Pump performance (P Level)(P0-P9~~8~~ or Auto)
   ii. Flow (L/min)(0.0-~~5.0~~ **5.5**)
   iii. Placement Signal (mmHg) [(~~2.5~~/CP/**5.5** = Sys/Dia) ~~(5.0: (30-60/+15)]~~
   iv. Purge Pressure (300-1100mmHg)
   v. Motor Current **(Pulsatile)**
   vi. Purge Fluid Infusion Rate (mL/hr)
   vii. Power AC Battery (60 minute battery life)
   viii. Distal Pulses

E. TROUBLESHOOTING:

1. For an in-depth description of troubleshooting and operation and description of all possible alarms, refer to Impella reference guide and user manual located on unit.
2. Impella 24-hour support 1-800-422-8666.

F. RELATED DOCUMENT(S):

1. **Sodium Bicarbonate in the Impella Purge System**

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

1. ~~Abiomed Corporation (2016).~~ Impella 5.0 with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation~~(2016).~~; **2016**
2. Impella 2.5/CP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation; **2016** ~~(2016)~~.
~~1.~~**3.** Impella RP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Hoag Hospital Cath Lab Policy 3.1.;~~(~~2008~~)~~. Abiomed Impella 2.5 Percutaneous Cardiac Assist Device.
~~2.~~**4.** McCulloch,B. (2011) Use of the Impella 2.5 in High-risk Percuataneous Coronary Intervention. Critical Care Nurse, 31(1), e1-e16.
5. Wiegang, D.L. (2011) AACN procedure manual for critical care. Saunders Elsevier. St. Louis: MO.
~~3.~~**6.** **Impella 5.5 with SmartAssist for Use During Cardiogenic Shock: Instructions for Use and Clinical Reference Manual. Danvers, MA Abiomed Corporation; 2020.**

Tri-City Medical Center
Oceanside, California

SODIUM BICARBONATE IN THE IMPELLA PURGE SYSTEM

A. **INDICATION(S):**
1. Sodium bicarbonate in 5% dextrose in water (D5W) is a safe alternative to heparin in D5W for the Impella purge system for patients intolerant to heparin or for whom heparin is contraindicated (e.g., heparin-induced thrombocytopenia (HIT) or bleeding).

B. **DOSING:**
1. Per physician order, Impella purge fluid may be changed to the following concentrations of sodium bicarbonate in milliequivalents (mEq) per ~~liter~~ **milliliter** (**m**L) of D5W:
   a. Sodium bicarbonate **0.0**25 mEq per ~~1~~**m**L D5W, rate to be determined by Impella purge system
   b. Sodium bicarbonate **0.0**5~~0~~ mEq per ~~1~~**m**L D5W, rate to be determined by Impella purge system

C. **MONITORING:**
1. When sodium bicarbonate is used in the Impella purge system, Abiomed, the manufacturer of the Impella device, has observed leakage from the yellow Luer connection on the purge sidearm, resulting in pump stops in the Impella 5.5.
   a. Reasons for leakage include:
      i. Longer support duration
      ii. Multiple purge cassette changes
      iii. Manipulating the pump during re-fixation
      iv. Elevated temperature near Luer-lock during three-point fixation
2. Monitor for pump stops and low purge pressure, which may indicate leakage. Refer to Ventricular Assist Device: Impella Nursing Care of the Patient Procedure for further instructions and resources for troubleshooting.

D. **REFERENCES:**

1. Hohlfelder B, et al. Anticoagulation with temporary Impella device in patients with heparin-induced thrombocytopenia: A case series. *Int J Artif Organs.* 2021:44(5):367-370.
2. Beavers CJ, et al. Bicarbonate-based purge solution during Impella support. *J Am Coll Cardiol.* 2022 Mar, 79 (9_Supplement) 633.

E. **RELATED DOCUMENT(S):**
1. Ventricular Assist Device: Impella Nursing Care of the Patient

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 12/01 **SUBJECT:** Administrator on Call

REVISION DATE: 11/02, 08/03, 03/06, 02/09, 03/11, 11/13, 04/14, 03/17, 02/20 **POLICY NUMBER:** 8610-281

Administrative Content Expert Approval:	~~11/19~~05/23
Administrative Policies & Procedures Committee Approval:	~~11/19~~06/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~01/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. **PURPOSE:**

1. To provide a process of administrative oversight and direction to ensure effectiveness of service continues during off hours (after business hours, weekends and holidays).

B. **DEFINITIONS:**

1. Administrator on Call: The Chief Operating Officer (COO), Chief Nurse Executive (CNE) and Chief Financial Officer (CFO) and senior leaders are assigned on a rotational basis to provide administrative oversight and direction.
2. Administrative Supervisor: The Administrative Supervisor on duty is responsible to the Directors and Managers for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the Chief Nurse Executive, Directors, and Nurse Managers.

C. **POLICY:**

1. The Administrator on Call (AOC) rotates weekly amongst the Senior Team.
2. The Administrative Supervisor will report any Level IV (Sentinel) occurrence/incident or significant patient care, risk management or operational issues to the Administrator on Call. Types of occurrences/incidents that are reportable to the Administrator on Call are:
   a. Any occurrence requiring reporting to the California Department of Public Health per Administrative Policy: Mandatory Reporting Requirements 236
   b. Significant risk management issues
   c. Significant physician, staff or operational issues
   d. Implementation of Hospital Incident Command System (HICS)
   e. Media contacts or potential media reportable events
   f. Non-availability of inpatient beds
3. All reported occurrences will include the following information in the Administrative Supervisor report:
   a. Brief description of event
   b. Individuals involved
   c. Action Plan (current and proposed)
   d. Impact on Organization or Outcome (current and potential)
   e. Communication Status
   f. Requested Assistance
      i. None Necessary
      ii. Approval
      iii. Plan Modification

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

1. Administrative Policy: Mandatory Reporting Requirements 236

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 01/81 **SUBJECT:** Helicopters on District Property

REVISION DATE: 05/89, 08/93, 10/97, 10/99, 05/03, 01/09, 09/10, 06/14, 05/20 **POLICY NUMBER:** 8610-207

Administrative Content Expert Approval:	~~03/20~~03/23
Administrative Policies & Procedures Committee Approval:	~~04/20~~04/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE**

1. To maintain a safe environment for all personnel on the helipad.

B. **POLICY**

1. The patient's physician shall request helicopter transport.
2. Departments requesting helicopter transport shall notify the Emergency Department (ED) as to the estimated time of arrival.
3. The Emergency Department (ED) Mobile Intensive Care Nurse (MICN) shall make appropriate in-house arrangements for landing and take-off.
4. The ED MICN shall be notified by the Aeromedical Dispatcher of helicopter landing.
   a. The ED MICN shall notify Security via the radio in radio room of estimated time of arrival of helicopter **in addition to the reason: rendezvous, pick-up, or drop-off** ~~**which also requires an EMT to be present.**~~.
   b. The Security Department will respond to the elevator alcove (and must turn off air handlers temporarily by pushing red button) to standby in case the fire suppression system needs to be activated. The elevator shall be kept in the locked position, available to the flight crew.
   ~~i.~~**c.** ~~If the patient is incoming, a~~**A**n ED technician shall meet the helicopter with a gurney, oxygen tank and I.V. pole and, when directed, assist the flight crew in the transfer of the patient and equipment.
5. The following safety rules shall be followed at all times.
   a. No running on the helipad.
   b. Doors to the helipad shall remain closed at all times (except during patient transfers to or from the helicopter).
   c. Visitors are not allowed on the helipad unless accompanied by the flight crew or TCMC Security personnel.
   d. Gurneys with mattresses, linens, or IV poles are not permitted within 50 feet of the aircraft when the blades are turning. Make sure all loose objects (i.e., MAST suits; debris) are secured on the helipad.
   e. Oxygen cylinders must be properly secured at all times (designated cylinder cart or underneath the gurney in the cylinder slot). At no time may cylinders be left unsecured.
   f. Wait for the pilot's approval before approaching or exiting the aircraft. Approach or exit the aircraft from the front in view of the pilot.
   g. Do not approach the helipad until the aircraft has landed on or lifted off the pad.
   h. Do not approach or exit the aircraft when the blades are turning. Do not allow ancillary personnel to approach the aircraft until the rotors have stopped turning.
   i. Tri City Medical Center heliport weight restriction for all medical air transportation is 10k

pounds maximum with a blade diameter of no more than 36 feet.

~~i.~~**j. The Security Department~~.~~ shall maintain a running logbook of helicopters on property to include: name and number of helicopter, the reason for coming to the hospital, and the touch down / take off times.**

Tri-City Medical Center

Quality Assessment
Performance Improvement (QAPI) Plan
2022 & 2023

A. **INTRODUCTION:**

1. Tri-City Medical Center (TCMC) is a community owned and operated California District Hospital. TCMC is a full service, acute-care hospital and includes an Inpatient Rehab, Home Health Services, Outpatient Behavioral Health, Inpatient & Outpatient Physical/ Occupational/ Speech/ Wound Therapy Services, Orthopedic and Primary Care Clinics~~. as well as the Tri-City Wellness & Fitness Center.~~ TCMC embraces a culture of excellence, safety and continuous improvement. Governance, leadership, frontline staff and the organized medical staff work together to promote a culture of safety and reliability. The goal is to have a culture characterized by teamwork with open discussion about quality and safety with a particular focus on systems and processes, supported by robust data and benchmarking.

B. **MISSION:**

1. Mission: To advance the health and wellness of the community we serve.
2. Vision: Be recognized as a healthcare system of choice in our community.

C. **VALUES**

1. The needs of our patients come first.
   a. Quality
   b. Caring
   c. Innovation
   d. Safety
   e. Integrity
   f. Stewardship

D. **CULTURE OF SAFETY**

1. A patient safety culture can be defined as the shared values, beliefs, norms, and procedures related to patient safety among members of an organization, unit or team. Patient safety is an organization-wide, integrated and coordinated approach designed to avoid injuries to patients from the care that is intended to help them. Safety is a priority and a property of systems and processes.
2. T**CMC** ~~ri-City Medical Center~~ is committed to the periodic assessment of the culture of safety within the **hospital district** ~~medical center~~ using evidence-based perception surveys to evaluate the culture and the effectiveness of interventions to strengthen the culture of safety over time.
3. Priorities are identified and categorized based on the Institute of Medicine (IOM) Six Aims of Healthcare:
   a. Safe: The organization supports the Just Culture Model as a framework for event investigation and response to events
   b. Timely: (e.g. reducing wait times and delays, timely test results)
   c. Effective: (e.g. reducing preventable mortality, **s**~~S~~epsis management, **s**~~S~~troke care)
   d. Efficient: (e.g. timely data analytics, clinical documentation improvement)
   e. Equitable: (e.g. reducing variation in our care, cultural diversity strategy)

Administrative Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/23	06/23	**08/23**	n/a	

f. Patient Centered: (e.g. Patient Rights and values guide all clinical decisions)

E. **HOSPITAL ORGANIZATION:**

1. Scope of the Plan
   a. The scope of the plan includes all patient-care services in all settings provided by staff, or through contracted services, and encompasses those departments and services that support patient care. This plan is designed to measure key processes and outcomes in order to understand and ensure the reliability of systems and processes, to prioritize improvement of systems or processes.
2. Roles and Responsibilities:
   a. The Board of Directors (BOD)
      i. The BOD oversees the accountability of the Medical Staff for the overall quality of patient care. Through the Quality Assurance/Performance Improvement (QA/PI) Committee, the BOD oversees the implementation and continuous evaluation of an organization wide, data-driven, QAPI program. –BOD responsibilities include overseeing the implementation of a QA/PI Plan that sets clear expectations for:
         1) Quality of Care
         2) Patient Safety
         3) Resource Allocation for measuring, assessing and evaluating organizational performance
         4) Eliminating harm to patients caused, in part, by complex processes and communication challenges
         5) Ensuring safe, timely, effective, efficient, equitable and patient-centered care
      ii. The BOD oversees the QA/PI program through regular reports that filter up through the Medical Quality Peer Review (MQPR) Committee. ~~Attachment illustrates the flow of information within the organization. The TCMC Organizational Chart is listed in Attachment .~~ The BOD acts as appropriate based on the recommendations from the above-mentioned committees as well as the Executive Team to ensure high quality patient care. The BOD ensures that Performance Improvement projects are appropriately prioritized and effectively implemented, as determined by Administration in collaboration with the BOD. The BOD also ensures that the QAPI activities are aligned with the organization's Mission, Vision and Strategic Goals.
      iii. Reports shall be presented to the BOD on a schedule. Based on the findings outlined within the quality reports, the BOD shall act to improve quality of care. Variations within the reporting schedule are permissible as long as the BOD maintains oversight of all these functions.
3. Medical Staff
   a. The TCMC Medical Staff, as outlined within the Medical Staff Bylaws, shall remain accountable for the overall quality of patient care. As such, the Medical Staff shall receive reports from the various Medical Staff committees accountable for monitoring ongoing care processes.
4. Executive Team
   a. TCMC's Executive Team consists of the Chief Executive Officer (CEO), The Chief Operations Officer (COO), the Chief Medical Officer (CMO), the Chief Financial Officer (CFO), and the Chief Nurse~~ing~~ Executive (CNE). The team actively oversees all QAPI activity within the organization. The CMO oversees the Quality department. -The Executive Team is proactively assessing the effect of upcoming healthcare reform and positioning the organization for success within a continuously changing operating environment.
5. Quality Assurance/Performance Improvement Committee
   a. The Quality Assurance/Performance Improvement (QA/PI) Committee, as outlined within its scope of service maintains an active role in the evaluation of quality measures through regularly scheduled meetings.

b. The following committees will be integrated into the hospital-wide QAPI program for oversight of quality initiatives which includes health outcomes, patient safety, and quality of care:

i. Infection Control Committee

1) The Infection Control Committee is a medical staff committee which selects initiatives, monitors and evaluates the Infection Control Program, and reports to the Medical Executive Committee, Medical Quality Peer Review Committee and Quality Assurance/Performance Improvement Committee. The Infection Control Committee is a multidisciplinary committee that shall approve, establish, and oversee the program for surveillance, prevention, and control of infections in order to improve the quality of care provided.

ii. Pharmacy and Therapeutics

1) The Pharmacy and Therapeutics (P&T) Committee is a medical staff committee accountable for the safety and quality of medication and therapy as it relates to pharmaceuticals. The committee discusses the hospital formulary and antimicrobial stewardship among other issues.

a) The Medication Safety Committee also reports to P&T, which is multidisciplinary. Issues discussed at this level may be referred directly to the MEC, as well as going to the QA/PI Committee for discussion before advancing to the BOD.

iii. Patient Safety

1) TCMC maintains an active Patient Safety Program in accordance with TCMC's service standard "Safety". TCMC's Regulatory & Accreditation Manager oversees integration and coordination of patient safety activities, which supports and promotes the mission, vision and values of TCMC. Please refer to the Risk **and** /Patient Safety Plan**s** for additional detail.

iv. Perioperative Surgical Home (PSH) Committee

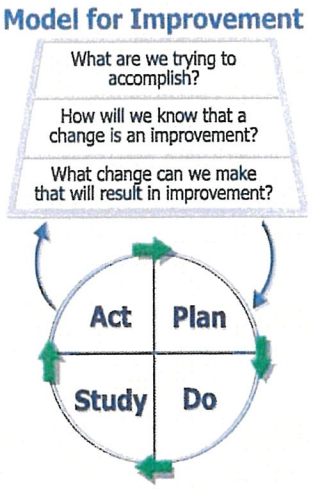
1) The program establishes an interdisciplinary team to collaborate in the care of patients undergoing colorectal surgery. The committee works to provide a consistent high quality, safe approach to our PSH program across the continuum.

F. PERFORMANCE IMPROVEMENT MODEL:

1. FOCUS PDCA:

a. "PDCA process involves planning for change or improvement constantly, and prioritizing and reprioritizing your improvement efforts based on carefully defined measurements and whether or not the problem involves high-risk, high-volume, or problem-prone processes, and if it dovetails with the goals of the organization" (Dulgacz, Retifo, & Greenwood, 2004).

i. F= Find a process to improve
ii. O= Organize a team that knows the process
iii. C= Clarify current knowledge of the process
iv. U= Understand causes of process variation
v. S= Select the process improvement



b. Plan: During this stage, TCMC analyzes and examines services in order to anticipate improvements. This includes collection of data and analysis of the process. The outcome of the "Plan" phase is a list of objectives used to move forward with improvement. Objectives include; appropriate indicators, best practices, and identifying a baseline to measure against. The recommended format for the PDCA cycle is the Institute for Healthcare Improvement (IHI) template. IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, * developed by Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement.

c. Do: In the DO phase, TCMC develops a measure, including the numerator, denominator, sample size and sample population. Also included is how and from what source that data will be gathered. Finally, it identifies the method and frequency of data interpretation and reporting chain (QA/PI, and other committees).

d. Check: After gathering data, TCMC analyzes the information and measures the effectiveness of the improvements. This review includes whether data collected was reliable and whether the variation in the studied process is stable. At this point benchmarks and threshold can be reset and any studies modified to better identify any special cause variances. All measures should be analyzed against the baseline data. This stage looks at what improvements were implemented and if they were effective. If the measure needs refinement, the DO phase is revisited at this point.

e. Act: The ACT phase is where a refined and perfected process showing a desired outcome is then implemented on a broader scale throughout the organization. In this way success on one unit can beget similar success within the organization. The Act phase circles back to the Plan stage for new implementation, thus ensuring continuous process improvement.

2. TCMC employs a variety of professional resources for benchmarking and identifying best practices including the National Database of Nursing Quality Indicators (NDNQI), the Collaborative Alliance for Nursing Outcomes (CALNOC), **Center for Medicare and Medicaid Services (**CMS) Value Based Purchasing data, **The Joint Commission (**TJC)/CMS Core Measure rates, Center for Disease Control (CDC), National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), C**ollaborative Healthcare** ~~HPSO~~ Patient Safety Organization **(CHPSO)**, the Institute for Healthcare Improvement (IHI), the National Healthcare Safety Network (NHSN), the National Association for Healthcare Quality (NAHQ), California Maternal Child Quality Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Health Services Advisory Group Quality Improvement Organization (HSAG QIO), Health Services Advisory Group Improvement Innovation Network (HSAG-HIIN), and other evidence-based sources.

G. **PRIORITIZATION AND PLANNING:**

1. The Medical Center's Quality **Department** and Patient Safety **Program**~~Department~~ facilitates an annual quality planning process which is transparent and inclusive to encourage a broad discussion across the medical center regarding quality improvement achievements, priorities for improvement in service, cost and outcomes. The process will be informed by a proactive risk assessment and review which includes the evaluation of:
   a. Performance on key quality outcomes, safety and process metrics compared to national benchmarks
   b. Patient and Family member feedback
   c. Pay for Performance metrics
   d. Regulatory requirements
   e. Event reporting, including near misses
   f. Results of survey data, including the Culture of Safety Survey and Leapfrog
   g. New legislative mandates
2. The Board of Trustees, Senior Leadership and Medical Staff Leadership working through the organization's standing committees shall establish priorities for performance improvement collaboratively. Criteria for prioritization are based on high-volume, high-risk, problem-prone,

patient experience and cost-related issues. In addition, data collected from performance-improvement and risk-reduction activities shall be considered in establishing priorities.

3. Established goals and priorities for improvement will be identified in the annually updated Quality and Patient Safety Plans which will be approved by the Quality Assurance/Performance Improvement Committee and BOD.

H. **DEPLOYMENT:**

1. The Medical Center charters multidisciplinary teams comprised of members with knowledge of the process to be improved.

I. **PERFORMANCE MEASUREMENT AND MONITORING:**

1. Measurement is conducted to establish the reliability of a process, to identify opportunities for improvement and to statistically evaluate clinical and organizational performance. Evaluation of clinical and organizational processes and outcomes is achieved through the development and ongoing monitoring of indicators based on aspects of performance, key organizational functions, identified dimensions of performance, and "best-practice" models or benchmarking. TCMC uses criteria to define its own performance measures including:
   a. The measure can identify the events it was intended to identify
   b. The measure has a documented numerator and a denominator statement or description of the population to which the measure is applicable. The measure has defined data elements and allowable values
   c. The measure can detect changes in performance over time
   d. The measure allows for comparison over time within the Medical Center or between the Medical Center and other entities
   e. The data intended for collection are available
   f. Results can be reported in a way that is useful to the organization and other interested stakeholders

J. **ERROR PREVENTION, RISK IDENTIFICATION, AND MITIGATION:**

1. Event Reporting, Trending and Analysis
   a. TCMC utilizes data from a variety of sources to identify areas of risk and to focus error-reduction initiatives. The areas monitored include:
   b. Hospital Trends: Event reports and generic trends are routinely analyzed by the Risk Management Department to identify harm or "near misses" or patterns of care that result in less-than-optimum outcomes.
   c. Patient Surveys: TCMC utilizes questions related to the patients' perception of their care and safety during their hospitalization. This information is analyzed and considered in developing risk-reduction strategies.
   d. Employees: Employees are encouraged to use the Chain of Command, Escalation process to report safety concerns to their supervisors, Senior Leadership and through the online reporting system (Patient Safety Tracker). TCMC supports a non-punitive reporting environment.
   e. Safety Committee Reports: The Safety Officer provides the Medical Board with an update regarding safety issues as presented and discussed at the Safety Committee. All issues that require additional review are referred to the appropriate Leadership.
2. Proactive Risk Assessment
   a. TCMC consistently seeks to reduce the risk of sentinel events and other medical/healthcare system harm occurrences by conducting its own proactive risk assessments, including but not limited to Failure Mode Effects Analysis (FMEA) and Hazard Vulnerabilities Assessment of selected, existing systems and processes. The Medical Center utilizes external agency reports, internal event reports, Leapfrog Survey, and any other recommendations related to patient safety. The purpose of the assessment is to identify a set of hazards, estimate how likely they are to occur, pick the most likely outcome, and prioritize improvement opportunities. -TCMC closely monitors its compliance with **TJC's**~~Joint Commission's~~ National Patient Safety Goals. This

proactive approach is undertaken so that processes, functions and services can be designed or redesigned to prevent harm to patients.

b. On an ongoing basis, the Chief Medical Officer and Director of Quality involve, as appropriate, members of the medical staff, senior leadership, hospital managers and hospital staff in risk analysis of major medical services/processes. Risk Management and Quality **Department** and Patient Safety **Program manager** ~~Department~~ collect error-reduction data from benchmark healthcare organizations and other industries.This information includes, but is not limited to, the following:
   i. **The** Joint Commission Sentinel Event Alerts
   ii. **Institute for Safe Medication Practices** (ISMP) Medication Safety Alerts
   iii. **Emergency Care Research Institute** (ECRI) Bulletins
   iv. CDC Bulletins
   v. CMS Hospital Compare Website

3. Utilizing the above data, as well as other internal and external metrics, the Director of Quality, in collaboration with Risk Management, makes recommendations to the Chief Medical Officer and the Quality Assurance/Performance Improvement Committee regarding priority aspects of care processes that are known to be high-risk or problem–prone. Collaboratively these individuals determine priorities for error reduction efforts and charter Teams/Committees to perform process redesign and improvements.

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 01/13

SUBJECT: Review of Tri-City Medical Center Information by Board Members

REVISION DATE: 04/16

POLICY NUMBER: 8610-210

~~Department Approval Date~~Administrative Content Expert Approval:	~~01/16~~05/23
Administrative Policies & Procedures Committee Approval:	~~02/16~~06/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	08/23
Audit, Compliance and Ethics Committee Approval:	04/16
Board of Directors Approval:	04/16

A. **PURPOSE:**

1. To ensure confidential information, patient information and employee information is protected in accordance with Tri-City Healthcare District's (TCHD) legal and ethical responsibilities when a Board member seeks information.

B. **POLICY:**

1. All requests by a Board member must be approved and confirmed by the Executive Management team member (C suite).
   a. Personnel Employment, health care records of patients and employees are not accessible or other information deemed confidential by legislative or regulatory requirements.
2. TCHD employees may only provide hard copies of District documentation to TCHD Board Members on site in their Board designated office space.
3. A TCHD Security Officer will be present as requested by the TCHD employee providing the information.
4. TCHD employees may not allow Board members to make electronic, manual or photo copies of the information being reviewed or remove the documentation from the premises.
5. Any particular set of documents may only be reviewed for up to two (2) hours per session and a maximum of one (1) session per week
6. Patient information, confidential information and privileged information gleaned from these sessions will not be discussed with any individuals unless the individual has a right to know such information.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES

ISSUE DATE: 10/87

SUBJECT: Identification of Employees and Non-TCHD Employees

REVISION DATE~~(S)~~: 01/09, 04/12, 04/15, 12/19

POLICY NUMBER: 8610- 436

Administrative Human Resources Content Expert Approval:	~~06/19~~03/23
Administrative Policies & Procedures Committee Approval:	~~08/19~~04/23
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee:	~~10/19~~06/23
Administration Approval:	~~11/19~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. **DEFINITION(S):**

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

B. **POLICY:**

1. All Workforce Members must wear their TCHD issued badge with picture and name clearly visible at all times while at TCHD per Administrative Policy: Secure Environment.
   a. Disfiguring or changing any portion of the photo ID badge is not allowed.
2. The TCHD issued badge is the method of identification for access control onto TCHD's premises during emergency situations. The TCHD issued badge should be kept with the Workforce Member at all times in case of disaster or emergency.
3. Department Directors or Supervisors must:
   a. Communicate the identification requirements to their workforce members.
   b. Counsel workforce members who do not comply with this policy.
4. On the first day of employment or engagement, Workforce Members must obtain a TCHD issued badge from Security or through appropriate process (for example, Business Visitors use **vendor management system**~~Reptrax~~, nursing students through the Education Department).
   a. Employees requiring access to sensitive/secure areas other than their own must have permission granted by the department's Director prior to authorization of the badge.
   b. Business Visitors must wear the **vendor management system**~~Reptrax~~ printed badge and check in with the **department leader/designee**~~charge nurse~~ prior to entering any clinical area per Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203.
5. Lost TCHD issued badges will be replaced by Security at the Workforce Member's expense. The department Director or Supervisor must **request**~~create a Badge Access form indicating~~ a badge replacement ~~and send to~~**from** Security~~ prior to issuing the new badge~~.
6. Upon termination, the Workforce Member's TCHD issued badge must be submitted to their Manager or the Human Resources Department (HR).
7. Failure to wear a TCHD issued badge properly when on duty may result in disciplinary action up to and including termination (see Administrative District Operations Policy: Secure Environment 204).
8. To the extent that any applicable collective bargaining agreement that is consistent with

applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.

~~C. FORM(S):~~
~~1. Request for Restricted Badge Access~~

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

1. Administrative District Operations Policy: Secure Environment 8610-204
2. Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203

Tri-City Medical Center	Emergency Department
PROCEDURE:	**DEATHS OF PEDIATRIC PATIENTS PRONOUNCED IN THE EMERGENCY DEPARTMENT**
Purpose:	Trauma Intervention Program (TIP) Representative if available will provide grief counseling for the family and assist in the coordination for the release of the remains.

A. **CRITERIA FOR REFERRAL:**

1. A child could be pronounced dead in the Emergency Department in three (3) major situations; in each of these situations, it is appropriate for a Trauma Intervention Program Representative (TIP) to be involved as available.
   a. Traumatic injury.
   b. Sudden Infant Death Syndrome (SIDS)/Medical Code.
   c. End stage of chronic illness.

B. **PROCEDURE:**

1. Provider shall attempt to introduce the TIP Representative to the family; TIP Representative shall explain their role and provide crisis intervention and information as appropriate in response to the family needs.
2. TIP Representative shall attempt to keep apprised of patient status and in consultation with physician, attempt to keep family informed of patient status and efforts at resuscitation, while assessing family coping on an on-going basis.
3. TIP Representative shall ordinarily accompany the physician when the parents are informed of the status and/or death of the patient and attempt to provide crisis intervention, information and education as appropriate to the situation. It is the primary responsibility of TIP to facilitate the grieving process for the family.
4. TIP Representative will attempt to ensure that designated staff shall discuss options for organ and tissue donation when appropriate in the grieving process and in accordance with regulatory requirements and hospital protocol.
5. When appropriate, TIP Representative explains the role of the coroner and ensures designated personnel contact the Office of the Coroner.
6. The Charge RN contacts the Administrative Supervisor and the Chaplain to inform them of the death of the patient, whether the patient is a coroners' case, status of organ/tissue donation and status of plans for disposition.

C. **GRIEVING PROCESS:**

1. TIP Representative shall coordinate with the Charge RN to facilitate identification of appropriate location to allow the family to spend some time with the decedent.
2. TIP Representative shall remain available to the family while they remain with the decedent, responding to any requests, providing grief counseling and support appropriate to the situation.

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/07, 02/11, 02/20, 03/23	06/20, 05/23	n/a	**07/20, 06/23**	08/20, 08/23	n/a	08/20

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**SUBJECT:**	**Leave Without Treatment (LWOT), Against Medical Advice (AMA), or Elopement**
REVISION DATE~~(S)~~: 07/10; 02/11, 08/15, 08/20		
Department Approval:	~~02/20~~03/23	
Department of Emergency Medicine Approval:	~~06/20~~05/23	
Pharmacy and Therapeutics Approval	n/a	
Medical Executive Committee Approval:	~~07/20~~06/23	
Administration Approval:	~~08/20~~08/23	
Professional Affairs Committee Approval:	n/a	
Board of Directors Approval:	08/20	

A. **DEFINITIONS:**
1. To define and provide guidelines for the management and documentation of patients who leave without treatment (LWOT), against medical advice (AMA) or elope.

B. **POLICY:**
1. All patients who request to leave the Emergency Department (ED) prior to evaluation by a ED physician or Allied Health Professional (AHP) and/or prior to completion of treatment will be encouraged to stay.
2. Patients who leave the ED AMA will be requested to sign the appropriate form.
3. Appropriate steps will be taken to attempt to locate patients who elope.

C. **PROCEDURES:**
1. Leaving without treatment (LWOT): Patients who have been registered for treatment, but have not been seen by the ED physician/AHP. Treatment may or may not have been started in triage.
   a. All patients who express the desire to leave before being seen by the ED physician/AHP will be encouraged to stay. As appropriate, a request may be made to the ED physician/AHP to speak with the patient.
   b. Patients who leave the ED prior to seeing a physician/AHP and have been assessed by the triage nurse or leave before seeing the triage nurse will have an ED clinical record started which will include the following as possible:
      i. Name
      ii. Chief complaint
      iii. Focused Assessment including mental status, airway, skin
      iv. ESI, Registered Nurse signature, time
      v. Vital signs
      vi. Any treatment started in triage
      vii. When known, the narrative is to include the reason and time the patient left without being seen and/or when it was discovered as well as attempts to locate the patient.
      viii. The narrative must explain the reasons for inability to collect any of the above information.
   c. For minors who leave the department prior to seeing a physician/AHP
      i. Every attempt must be made to contact the parents or guardian to inform them of the minor's presence in the ED.
      ii. Document the contact or the attempt to contact the parents or guardian. .

iii. The exception to the above are minors who are emancipated or on active military duty. Other exceptions are when the complaint involves a sexual disease, pregnancy, sexual assault and drug or alcohol related problems.

d. For patients who are not oriented or who are expressing suicidal/homicidal ideation, consult with the physician on duty to determine if a 5150 hold is appropriate.

e. Attempt to have patient sign "Left Without Treatment Form".

2. Against Medical Advice (AMA): Patients who have been seen by the ED physician/AHP and who decide to leave before treatment is completed.
   a. When a patient expresses the desire to leave AMA, the ED physician/AHP shall be informed and every effort shall be made to encourage the patient to remain in the ED.
   b. The ED physician/AHP must attempt to provide the patient with information regarding the potential consequences of the action to include the risks involved in leaving, the benefits of continuing the treatment, and any alternatives so that the patient can make an informed decision.
   c. Whenever a patient demands to leave before treatment is completed or contrary to the advice of the ED physician/AHP, a "Leaving Hospital Against Medical Advice" form shall be completed.
   d. If the patient refuses to sign this form, the notation "patient refuses to sign" shall be made in the space provided for the patient's signature. The witness shall sign his/her name, the exact time, and date.
   e. A competent adult that is not on any legal hold or court ordered quarantine or detention may not be detained against his/her wishes.
   f. Precautions shall be taken to assure the patient leaves the hospital in a safe manner.
   g. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to encourage the patient to complete treatment, and any patient discharge instructions that were given.
3. Elopement – non-5150: Patients who have been seen by the physician/AHP and left the ED without informing staff.
   a. When it is discovered that a patient has left the ED without informing the staff, the ED Charge RN shall be notified immediately. The patient's family, primary physician, Manager/Director or Administrative Supervisor shall be notified as appropriate.
   b. Attempts shall be made to locate the patient. Hospital security and/or law enforcement shall be notified as appropriate.
   c. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to locate patient, and who was notified of the patient's elopement.

D. DOCUMENTATION

1. Documentation on the patient's chart shall include a summary of the events surrounding the incident, attempts to locate patient, and who was notified of the event.

E. FORMS:

1. AMA Form (8723-1001-English and 8723-1003-Spanish) Sample
2. LWOT Form (7010-1027-English) Sample

F. REFERENCES:

1. California Hospital Association, *EMTALA – A Guide to Patient Anti-Dumping Laws, 8th ed.* (2012)
2. Title 22, California Code of Regulations, Section 70707(b)(10)

8723-1001 Leaving Hosiptal Against Medical Advice Sample

3-Hole 1/4 1 3/8 c-to-c

Patient's Name: _____

I am voluntarily leaving the hospital against the advice of Dr. _____ and a representative of the hospital administration.

I have been told by the doctor about the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

I hereby release the doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects which may result from this action.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Signature: _____
(patient/parent/conservator/guardian) Date/Time

If signed by other than patient, indicate relationship:

_____

Witness: _____
Date/Time

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks:

_____

Signature: _____
(physician) Date/Time

Affix Patient Label

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

8723-1001
(Rev. 2/10)

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

White - Chart Yellow - Patient

7010-1027 Left Without Treatment Form (LWOT) Sample

I am aware that I have a right to a medical screening examination by a physician or other qualified medical personnel to determine if an emergency medical condition exists. I am also aware that if an emergency medical condition does exist, lack of immediate treatment could result in severe impairment of my health up to and including death.

I am aware that I am being offered a medical screening examination by Tri-City Medical Center. I have had an opportunity to have questions answered. I have chosen to decline the offered medical screening examination or further treatment at this time.

I do hereby release Tri-City Medical Center, its officers and its affiliated subsidiaries, directors, employees, agents and independent contractors attending me from all responsibility for any and all consequences which may occur as a result of my leaving without a medical screening examination.

Patient signature	Date	Time

Witness

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

7010-1027
(Rev. 3/10)

LEFT WITHOUT TREATMENT FORM (LWOT)

White - Chart Yellow - Patient

Affix Patient Label

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE: **SUBJECT: Pediatric Patients, Care of**

REVISION DATE~~(S)~~: 09/07; 02/11, 08/20

Emergency Department Approval:	**~~02/20~~03/23**
Department of Emergency Medicine Approval:	**~~06/20~~05/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/20~~06/23**
Administration Approval:	**~~08/20~~08/23**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	**08/20**

A. **DEFINITIONS:**
1. To establish guidelines for the care of pediatric patients.

B. **POLICY:**
1. Emergency care is provided to all patients presenting with an injury or an illness, regardless of age.
2. It is important to recognize the child's developmental age and how that influences the child's reaction to an illness.

Infancy	A time of trust development. Attachment to parent figures occurs and separation causes great protest. Parents should be allowed to stay with their infant whenever possible.
Toddlers	Developing autonomy and have a fear of mutilation. Their reactions to intrusive procedures can be physically aggressive, such as screaming, hitting, pushing, and running away are typical.
Preschoolers	A sense of omnipotence. They are able to utilize some self-control during pain and may feel ashamed when unable to maintain it.
School Age	Industrious and are challenged by their physical and cognitive abilities. Maintenance of privacy and control are important. Pride in independence can inhibit school-age children from seeking support, although they shall accept it if offered.
Adolescence	A state of conflict. Independence, sense of self, and peer relationships are paramount. Privacy during examination and opportunities for and encouragement of their questions should be provided.

C. **PROCEDURE:**
1. All pediatric patients shall have their weight taken and documented on the medical record. A head circumference may be obtained if indicated.
2. All pediatric patients shall be assessed and have a full set of vital signs taken including height and weight on arrival. Reassessments shall be done on patients with a change of provider, at shift change, and every 2 hours or more often as appropriate to their chief complaint.
3. When a pediatric patient is discharged, the parents or legal guardian shall have the discharge plan of care explained. On discharge, they shall receive an instruction sheet and any physician referrals.

D. **DEVELOPMENTAL AGE CONSIDERATIONS WHEN TREATING PEDIATRIC PATIENTS:**

1. Infant (Birth to 12 months)
   a. Developmental Considerations:
      i. Trust versus mistrust
      ii. Need to have basic needs met
      iii. Attachment to primary caretaker
      iv. Oral Stage
      v. Limited ability to communicate
   b. Major Fears
      i. Separation anxiety
      ii. Stranger anxiety
   c. Interventions
      i. Minimize separation from parents.
      ii. Use security objects (e.g., stuffed animal, blanket) if separation is unavoidable.
      iii. Prepare parents for procedures and allow them to comfort infant.
      iv. Use soothing voice and gentle touch.
      v. Provide distraction with brightly colored toys.
2. Toddler (1 – 3 years of age)
   a. Developmental Considerations:
      i. Autonomy versus shame and doubt
      ii. Seeks independence
      iii. Negativism
      iv. Threatened by changes in routine
      v. Curious explorer
      vi. Sensorimotor cognition
      vii. Limited ability to communicate, reason, and understand time
      viii. Little concept of body integrity
   b. Major Fears
      i. Separation anxiety
      ii. Stranger anxiety
      iii. Lack of familiar environment and routines
      iv. Bodily injury
   c. Interventions
      i. Minimize separation from parents.
      ii. Use security objects if separation is unavoidable and assure toddler of parent's return.
      iii. Provide parents with information and allow expression of concerns and feelings.
      iv. Encourage toddler to make choices and participate in care when possible.
      v. Limit use of restraints and allow as much mobility as possible.
      vi. Allow for verbal (crying) and motor (kicking) protesting.
      vii. Tell toddler immediately before a procedure that it will occur and explain it in simple terms.
      viii. Provide praise.
3. Preschool Age (3 –5 years of age)
   a. Developmental Considerations:
      i. Initiative versus guilt
      ii. Conscience formulation
      iii. Feelings of being punished
      iv. Preoperational cognition, egocentric, magical thinking
      v. Inquisitive
      vi. Acquiring better language skills
   b. Major Fears
      i. Separation anxiety

ii. Mutilation and bodily injury
iii. Accidents and illnesses are punishment

c. Interventions:
i. Minimize separation from parents. If separation is unavoidable, assure child of parents' return.
ii. Encourage child to make choices and participate in care when possible.
iii. Be realistic and truthful, explaining at child's level of understanding.
iv. Reinforce that accidents and illnesses are not punishment.
v. Give explanations before procedures through role play, use of puppets and dolls, and letting child handle safe hospital equipment.
vi. Allow expression of feelings and concerns through play, drawings, and verbalization.
vii. Use adhesive bandages liberally; child may fear that all his or her blood will leak out.

4. School Age (6 – 12 years of age)
a. Developmental Considerations
i. Industry versus inferiority
ii. Sense of mastery
iii. Concrete cognition
iv. Active learners
v. Well-developed language skills and concept of time
vi. Concerns about body image

b. Major Fears
i. Mutilation and pain
ii. Accidents and illnesses are punishment
iii. Death
iv. Concerns about body image

c. Interventions:
i. Involve parents in care.
ii. Encourage child to participate in care when possible.
iii. Explain procedures in advance using models, drawings, or other audiovisual materials.
iv. Respect child's modesty.

5. Adolescent (13 – 18 years of age)
a. Developmental Considerations:
i. Identify versus role confusion
ii. Can deal with reality
iii. Abstract cognition
iv. Reasoning becomes more logical and idealistic
v. Rapid mood swings
vi. Rapidly changing body image

b. Major Fears:
i. Loss of control and independence.
ii. Threat of change in body image
iii. Restriction of physical activities
iv. Rejection from peers
v. Death

c. Interventions:
i. Encourage adolescent to make choices and participate in care when possible.
ii. Give realistic and truthful explanations.
iii. Use body diagrams or models to explain procedures.
iv. Respect adolescent's need for privacy.

6. Involve parents in care, but attempt to give adolescent time alone with health care professional to ask questions, clarify information, and discuss concerns

E. MANIFESTATIONS OF STRESS IN PARENTS OF CRITICALLY ILL CHILDREN:

Stress Reaction	Presentation
1. Reduced ability to utilize information	Parents repeat the same questions to different staff members as they seek information and explanations. Parents need repetition and consistent information because they may not hear the information when they are given it the first time.
2. Decreased ability to think clearly and problem solve.	Parents feel confused and are unable to organize their thoughts and prioritize their concerns.
3. Reduced ability to master tasks.	Parents lose their ability to function and mobilize their own resources.
4. Decreased sense of personal effectiveness	Parents experience feelings of loss, incompetence, failure, helplessness, and guilt. Need to be told what they can do.
5. Reduced ability to make effective, constructive decisions	Parents may distort facts and events and fill in the gaps with exaggerated information. This can affect the parents' ability to make decisions regarding the child's care.
6. Heightened or decreased sensitivity to self	Parents may become easily irritated and preoccupied with personal somatic complaints, or they may be unaware of their own physical needs.
7. Decreased sensitivity to environment	Parents may lose touch with events happening around them and miss subtle cues and pieces of information.

Tri-City Medical Center	Emergency Department
PROCEDURE:	**TRANSFER OF PEDIATRIC PATIENTS**
Purpose:	To provide a procedure for transporting pediatric patients from the Emergency Department to an appropriate facility.

A. **PROCEDURE:**

1. Non Acute Transfer:
   a. Call Rady-Children's (RC) Operator.
      i. If surgical reason, Unit Secretary to ask if Surgeon available to accept a transfer.
      ii. Emergency Department (ED) Physician to discuss reason for surgical intervention at RC with available Surgeon.
      iii. When transfer is accepted and Bed is assigned:
         1) Call Ambulance Service for transfer.
         2) Providers to complete patient electronic record.
         3) Unit Secretary to prepare transfer paperwork and supporting records, e.g. film CD, ECG, lab results.
         4) RN to call report to receiving unit.
   b. Additional transfer locations based on insurance are Palomar, Kaiser, and Naval Hospital.
2. Critical Transport:
   a. Unit Secretary to call the CHET Team at 1-858-277-3404.
   b. ED Physician to discuss patient stability, needs and interventions performed and/or in progress.
   c. CHET Team to communicate mode of arrival: Air or Ground transport.
   d. Unit Secretary to notify Security for all air transports to prepare for the helicopter landing.
   e. If Rady-Children's is unable to accept the transfer, the Charge Nurse or designee shall call the most appropriate pediatric facility until a site is able to accept the patient.

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/07, 02/11, 02/20, 03/23	06/20, 05/23	n/a	**07/20, 06/23**	08/20, 08/23	n/a	08/20

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**10/09**	**SUBJECT:**	**Influx of Infectious Patients: Epidemic Influenza or Other Respiratory Transmitted Disease**
REVIEW DATE~~(S)~~:	**11/12, 08/19**		
REVISION DATE~~(S)~~:	**10/09, 11/16,**		
Department Approval:		**~~04/19~~12/22**	
Infection Control Committee Approval:		**~~04/19~~04/23**	
Pharmacy & Therapeutics Committee Approval:		**~~05/19~~05/23**	
Medical Executive Committee Approval:		**~~06/19~~06/23**	
Administration Approval:		**~~07/19~~08/23**	
Professional Affairs Committee Approval:		**n/a**	
Board of Directors Approval:		**08/19**	

A. **PURPOSE:**
1. Provide a plan to manage patients requiring Droplet or Airborne Precautions when the availability of rooms, staff, supplies or other recourses are limited. This plan is intended to provide a decision pathway for initiating Code Triage and Code Orange status.

B. **SUPPORTIVE DATA:**
1. Influenza epidemic or pandemic are different from many threats for which public health and the health-care system are currently planning:
   a. A pandemic will last much longer than most other emergency events and may include "waves" of influenza activity separated by months (in 20th century pandemics, a second wave of influenza activity occurred 3 to 12 months after the first wave).
   b. The numbers of health-care workers and first responders available to work can be expected to be reduced; they will be at high risk of illness through exposure in the community and in health-care settings, and some may have to miss work to care for ill family members.
   c. Because of how widespread an influenza pandemic may turn out, resources in many locations could be limited.

C. **POLICY:**
1. Most likely scenarios that would result in an influx of infectious patients include, but are not limited to:
   a. Epidemic influenza
   b. Epidemic gastroenteritis
   c. Epidemic exposure to suspected biological agent
   d. Epidemic biological agent (such as smallpox)

D. **PROCEDURE**:
1. Influx is localized to the Emergency Department (ED) due to:
   a. Worried well seeking information or prophylaxis.
   b. Necessity for treatment of influenza symptoms which will result in discharge from ED:
      i. Initiate Code Triage - during code triage implement limited command center during business hours.

ii. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed - Administrative Supervisor
iii. Refer to Disaster Lockdown policy in the event of uncontrolled access.

c. The Emergency Operations Plan will be initiated as needed.

2. Level 1: 1-5 patients waiting for bed placement requiring isolation precautions
   a. Notify Administrative Supervisor - ED Charge Nurse.
   b. Notify Shift Supervisor, Administrator On Call, ED Clinical Manager, Safety Officer, Director of Engineering, and Infection Preventionist as directed - Administrative Supervisor.
   c. Notify Pulmonary lead (760) 802-1974 perform ventilator inventory.
   d. Assess all current inpatients for discharge or transfer potential - Bed Supervisor.
   e. Contact local skilled nursing facilities for bed availability - Case manager.
   f. Contact Public Health Department for coordination of patient placement - Infection Control.
   g. Exceed the state mandated nurse-patient ratio, if needed - Chief Nurse Executive.
   h. Post security at ED entrances.
   i. Refer to Disaster Lockdown policy in the event of uncontrolled access.
3. Level 2: 6-10 patients waiting for bed placement requiring isolation precautions
   a. Implement Patient Care Procedure, Code Triage Alert - Emergency Department.
   b. Assess all current inpatients for discharge or transfer potential - Bed Coordinator.
   c. Consider contacting local skilled nursing facilities for bed availability - Case manager.
   d. Consider contacting the Public Health Department for coordination of patient placement - Infection Preventionist/Safety Officer.
   e. Refer to Disaster Lockdown policy in the event of uncontrolled access.
4. Level 3: More than 11 patients waiting for bed placement requiring isolation precautions
   a. Activate Code Orange - Chief Executive Officer (See Emergency Operations Plan).
      i. An internal disaster is declared when surge progresses beyond the ability of an initial localized response to contain or suppress the event.
      ii. In the event of an incident occurring outside of the Hospital, the need for mass casualty support will be identified by the County Office of Emergency Services and an "Annex D" notification will be transmitted by County Communications System to the Emergency Department (ED). An "Annex D" indicates an event has occurred somewhere and that patients with epidemic influenza or respiratory transmissible disease may be sent to the hospital. The ED will notify the Administrator-on-Call or Operations Supervisor of the Annex D notification, who will in turn advise the other members of the Emergency Command Staff. See Appendix A for Pandemic Alert Phases.
         1) Contact the County of San Diego Public Health: at 858-565-5255. . This is available 24/7 and to be utilized for emergencies only.
         2) Activate Code Orange (if not already activated).
      iii. Consider isolating a section of ED (Contact Engineering to facilitate).
   b. For Novel viruses - Patients with oral temperatures >101˚F on two successive readings will require Standard and Droplet Precautions. If the suspect pathogen is found to be transmitted via airborne route, then Standard and Airborne Precautions will be initiated, if available. If the suspect pathogen is found to be transmitted via direct/indirect (fomite) routes, then Contact Precautions will be added.
   c. Use Airborne Illness Isolation Rooms for admissions: 143, 243, 443, 287, 387, 487 and MCH rooms 200, 201
   d. When AIIR's are fully utilized, use a private room with portable HEPA filter (call Engineering).
   e. Expedite discharge of inpatients who are able – Case Management.

f. Consider available options for designating an inpatient isolation precautions unit or clinical area.
g. Consult with Staffing Department for staff resource management.
h. In the event of Epidemic gastroenteritis
    i. Assess need for:
        1) Contact Enteric Precautions (in addition to Standard)
        2) Inventory private rooms available.
        3) When necessary cohort with like condition.
        4) Create a cohort patient care area using available facilities and considering all options (e.g., in the Assembly Rooms 1-3 move Child Care off site).
        5) Create patient care areas in the parking lot.
i. Supplies
    i. MDC to perform daily inventory of medical supplies and isolation supplies and report.
    ii. Supplies maintained on a three tier level.
    iii. Local inventor of stock (floor stock) will be maintained at higher levels.
    iv. When depleted, utilize central storage (in-house) of critical supplies including PPE, and strategic medical supplies will be maintained.
    v. When central storage is depleted, distributer will maintain supply of inventory readily available for distribution when needed.
j. Quarantine - Tri City Medical Center would most likely be a Type C Quarantine facility. Type C facilities care for actual and suspect cases. This would include individuals with:
    i. Compatible symptoms and laboratory confirmation of the specific pandemic strain of influenza (confirmed case).
    ii. Compatible symptoms following suspected/known exposure with pending laboratory confirmation (probable case).
    iii. Atypical clinical symptoms following suspected or known exposure (suspect case).
    iv. Contacts under surveillance that become febrile with oral temperatures > 101° F (38°C) on two successive readings.
    v. Individuals with other associated symptoms such as coughing and fever.
    vi. Ill persons requiring specialized health care may be isolated in a hospital; but, depending on their medical needs, persons may also be isolated at home or in a designated health care facility or community-based facility.
    vii. For non-hospital isolation, home/personal residence isolation is preferred and will be utilized first unless a contraindication exists such as homelessness, non-compliance with isolation, or at-risk persons in the home with inability to maintain separation.
    viii. Transportation to an isolation facility will be coordinated with the EMS DOC.
k. Bed availability
    i. If there are no hospital beds available, contact the County of San Diego Public Health for guidance 858-565-5255.
l. Prophylaxis Immunization requirements:
    i. Implement mass prophylaxis protocols.
    ii. Required for entry to facility if vaccine is available. NOTE: Prophylaxis may not be available.
    iii. If no prophylaxis is available, individuals working with confirmed and suspect cases must use ~~Standard, and Airborne~~ **Droplet** Precautions **in addition to Standard Precautions**.

iv. Strict respiratory hygiene to include frequent hand hygiene and masks must also be enforced.
v. The Safety and Security Officer or designee will ensure that all personnel who enter the facility have been recently prophylaxed with vaccine or antivirals if available and are on the list of individuals who may enter the facility

m. Staffing:
i. Maintain pre-epidemic staffing levels, if possible.
ii. If the number and types of staff are insufficient to meet the needs of the number of people being contained, additional staff may be requested through the **San Diego** County Emergency Operations Center (EOC).
iii. Planning Chief will compile a list of individuals who can enter the facility. This should be established in collaboration with the Public Health Officer and/or the authorized designee.
iv. The list will include the smallest possible number of people required for patient care, disease investigation, and facility maintenance (physicians, nurses or aides, laboratory personnel, housekeeping, dietary, and maintenance personnel, etc.).
v. This list will be kept by the Personnel Pool Unit Leader or designee.
vi. Consider cross training of staff to facilitate work flow.
vii. If isolation unit is established, consider ancillary staffing including on-unit Radiology, Lab and Respiratory Care staffing.
viii. If child care is provided, screening for signs of illness including temperature reading and recording may be indicated.

n. The Employee Health Director or designee will:
i. Ensure that employees monitor and report their temperature and any symptoms every 12 hours until -
1) 14 days after they are vaccinated or
2) 14 days after they completed their antiviral prophylaxis or
3) 5 days after the date of last patient contact.
ii. Those personnel on the list to enter the facility that are not vaccinated or on prophylaxis drugs will also monitor and report their temperature and any symptoms every 12 hours and use personal protective equipment (PPE) while in the facility until 14 days after they have been vaccinated, placed on antiviral therapy when it becomes available, or 5 days from date of last contact.
iii. This access monitoring system will include a confidential log of all persons who enter and leave, including staff, and will include each person's vaccination, antiviral treatment status, temperature, and any symptoms reported.
iv. Until 14 days after immunization, once vaccine is available, or completion of antiviral therapy, all personnel will check their temperature every 12 hours. At the beginning of each shift, they are to report their temperatures or any illness to the person assigned to monitor employees' health. On off days, they are required to be in telephone contact each morning to report their temperatures. Once the waiting period is over, personnel are not required to routinely check their temperatures. They are still required to report any illness.
v. Staff with febrile oral temperatures >101˚F on two successive readings will not be able to work.

o. Medical Staff Office
i. Refer to Medical Staff Disaster Plan (See Medical Staff Policy #8710-553).

p. Extended Epidemic- PRIORITIES
i. Sustained staffing
ii. Vaccine acquisition and distribution

iii. Antiviral medication acquisition and distribution
iv. Mask supply and reuse
v. Bed availability
vi. Security

	2 weeks	4 weeks	2 months	6 months
Staffing and possible quarantine	Consider housing staff at hospital	Request staff from outside effected areas	Train additional staff to perform non-critical functions	
Medication supply	Request additional vaccine and antiviral medications	Reprioritize vaccination and antiviral distribution strategies		
Supplies	Request additional masks tissues, disposal bags and hand sanitizer	Consider changes to infection control practice related to reuse of supplies	Consider making gauze masks, if supply of disposables is nearly exhausted	
Bed availability	Use available private rooms; cohort with like illness	Consider transfer to another facility		
Security	24 hour restricted access to essential staff only			

E. **ATTACHMENT(S):**
1. World Health Organization (WHO) Stages of Alert Phases of a Pandemic

F. **RELATED DOCUMENT(S):**
1. Emergency Operations Procedure Manual General Information Policy: Emergency Operations Plan

G. **REFERENCE(S):**
1. Healthcare Surge-Emergency Preparedness https://www.calhospitalprepare.org/healthcare-surge **(Updated 11/23/2020- reviewed 12.12.2022)**
2. California Department of Public Health: Infectious Disease & Pandemic Influenzahttp://cdphready.org/category/infectious-diseases-pandemic-influenza/
3. CDPH: AFL 18-09 Requesting Increased Patient Accommodations including Medical Surge Tent Use January 12, 2018 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-18-09.aspx
4. **SD County Office of emergency services, Operational Area Emergency Center**
~~3.~~ **Office of Emergency Services (sandiegocounty.gov)**
5. **CDPH: AFL 22-23 Guidance for response to Surge in Respiratory Viruses**

Appendix A

World Health Organization (WHO) Stages of Alert Phases of a Pandemic
Pandemic Stage Definition

Novel (new) Virus Alert
- Novel virus detected in one or more humans
- Little or no immunity in the general population
- Potential, but not inevitable precursor to a pandemic

Pandemic Alert
- Novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area

Pandemic Imminent
- Novel virus causing unusually high rates of morbidity and mortality in widespread geographic areas

Pandemic
- Further spread with involvement of multiple continents

Second Wave
- After the number of cases falls and the pandemic appears to be ending, typically a second wave of cases occurs within several months

Pandemic Over
- Cessation of successive pandemic "waves", accompanied by the return (in the U.S.) of the more typical wintertime "epidemic" cycle

Tri-City Health Care District
Oceanside, California

Infection Control

ISSUE DATE: 10/07	**SUBJECT: Mold Abatement**
REVISED DATE~~(S)~~: 08/14, 08/17, 09/20	**STANDARD NUMBER: IC. 13.3**
Department Approval:	**~~05/20~~05/23**
Infection Control Committee Approval:	**~~05/20~~05/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/20~~07/23**
Administration Approval:	**~~09/20~~08/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/20**

A. **INTRODUCTION:**

1. Molds and fungi can be found anywhere inside or outside throughout the year. About 1000 species of mold can be found in the United States with more than 100,000 known species worldwide. When excessive moisture or water accumulates indoors, mold growth often will occur, particularly if the moisture problem remains uncorrected. While it is impossible to eliminate all molds and mold spores, controlling moisture can control indoor mold growth. Moisture control is the key to mold control. When water leaks or spills occur indoors - act promptly. Any initial water infiltration should be stopped and cleaned promptly. A prompt response (within 24-48 hours) and thorough clean- up, drying, and/or removal of water-damaged materials will prevent or limit mold growth.
2. Delayed or insufficient maintenance may contribute to moisture problems in buildings. Molds may cause localized skin or mucosal infections but, in general, do not cause systemic infections in humans, except for persons with impaired immunity, AIDS, uncontrolled diabetes, or those taking immune suppressive drugs.

B. **PURPOSE:**

1. The purpose of mold remediation is to correct the moisture problem and to remove moldy and contaminated materials to prevent human exposure and further damage to building materials and furnishings. Porous materials that are wet and have mold growing on them may have to be discarded because molds can infiltrate porous substances and grow on or fill in empty spaces or crevices.

C. **PROCEDURE:**

1. Infection Preventionist Safety Officer and Manager of Facilities will:
   a. Provide consultation during water damage remediation and mold abatement.
   b. Inspect abatement areas for compliance with recommended practices.
   c. Review indication for environmental cultures or volumetric air sampling.
2. Facility Engineering staff will:
   a. Participate in training process for mold remediation activities and construction barrier containment.
   b. Follow remediation precautions as outlined in this plan.
   c. Notify Infection Preventionist and Safety Officer about water intrusion and remediation.
   d. Follow procedure for containment found in Infection Control Construction Permit: ICRA
   e. Coordinate the remediation of the mold by trained staff,
   f. Wear the appropriate PPE during remediation.
   g. Assess the extent of mold contamination for appropriate remediation activity level.
3. Mold Remediation/Cleanup Methods

a. A variety of cleanup methods are available for remediating damage to building materials and furnishings caused by moisture control problems and mold growth. The specific method or group of methods used will depend on the type of material affected. Water damaged areas should be dried within 48-72 hours of water exposure. It is recommended that dehumidifiers be used for this purpose because fans can cause aerosolization of mold spores. Some methods that may be used include the following:

b. Wet Vacuum - can be used to remove water from floors, carpets, and hard surfaces where water has accumulated. They should not be used to vacuum porous materials, such as gypsum board. Wet vacuums should be used only on wet materials, as spores may be exhausted into the indoor environment if insufficient liquid is present. The tanks, hoses, and attachments of these vacuums should be thoroughly cleaned and dried after use since mold and mold spores may adhere to equipment surfaces.

c. Damp Wipe - Mold can be removed from nonporous surfaces by wiping or scrubbing with a hospital approved disinfectant. It is important to dry these surfaces quickly and thoroughly to discourage further mold growth.

d. HEPA Vacuum - HEPA (High-Efficiency Particulate Air) vacuums are used for final cleanup of remediation areas after materials have been thoroughly dried and contaminated materials removed. HEPA vacuums also are used for cleanup of dust that may have settled on surfaces outside the remediation area. Care is taken to assure that the filter is properly seated in the vacuum so that all the air passes through the filter. When changing the vacuum filter, wear N-95 respirators, appropriate personal protective clothing, gloves, and eye protection to prevent exposure to any captured mold and other contaminants. The filter and contents of the HEPA vacuum must be disposed of in impermeable bags or containers in such a way as to prevent release of the debris.

e. Disposal of Damaged Materials - Building materials and furnishings contaminated with mold growth that are not salvageable should be placed in sealed impermeable bags or closed containers while in the remediation area. These materials can usually be discarded as ordinary construction waste. Large items with heavy mold growth are covered with polyethylene sheeting and sealed with duct tape before being removed from the remediation area.

f. Use of Biocides - The use of a biocide, such as chlorine bleach, is indicated when immuno-compromised individuals are present. A dilution of 500 ppm is recommended for this purpose (dilution to attain this concentration is 1 part bleach to 100 parts water). Containers shall be labeled appropriately and discarded after use. When you use biocides as a disinfectant or fungicide, always ventilate the area well and apply appropriate PPE, including respirators.

g. Never mix chlorine bleach solution with other cleaning solutions or detergents that contain ammonia because this produces highly toxic vapors and create a hazard to workers.

4. Mold Remediation Guidelines

a. Level I: Small Isolated Areas (10 sq. ft or less) - e.g., ceiling tiles, small areas on walls.

i. Install Infection Control Containment. Containment level to be determined by the Infection Preventionist and Engineering supervisor.

ii. Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.

iii. N-95 disposable respirators are used. Gloves and eye protection are worn.

iv. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.

v. The work area and egress area are cleaned with a damp cloth or mop and a hospital approved disinfectant.

vi. All areas are left dry and visibly free from contamination and debris.

b. Level II: Mid-Sized Isolated Areas (10-30 sq. ft.) – e.g., individual wallboard panels.

i. Install Infection Control Containment. Containment level to be determined by the

Infection Preventionist and Engineering supervisor.

ii. Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.

iii. N-95 disposable respirators are used. Gloves and eye protection are worn.

iv. Surfaces in the work area that could become contaminated are covered with a secured plastic sheet(s) before remediation to contain dust/debris and prevent further contamination.

v. Dust suppression methods, such as misting (not soaking) surfaces prior to remediation, are used.

vi. Contaminated materials that cannot be cleaned are removed from the building in a sealed impermeable plastic bag. These materials are disposed of as ordinary waste.

vii. The work area and egress areas are HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.

viii. All areas are left dry and visibly free from contamination and debris.

c. Level III: Large Isolated Areas (30 –100 square feet) – e.g., several wallboard panels.

i. The following procedures may be implemented depending upon the severity of the contamination:

1) Install Infection Control Containment. Containment level to be determined by the Infection Preventionist and Engineering supervisor.

2) Trained workers conduct remediation, coordinated and supervised by the Engineering department. The staff is trained on proper clean-up methods, personal protection, and potential health hazards.

3) N-95 disposable respirators are used. Gloves and eye protection are worn.

4) Surfaces in the work area and areas directly adjacent that could become contaminated should be covered with a secured plastic sheet(s) before remediation to contain dust/ debris and prevent further contamination.

5) Seal ventilation ducts/grills in the work area and areas directly adjacent with plastic sheeting.

6) Dust suppression methods, such as misting (not soaking) surfaces prior to mediation, are used.

7) Contaminated materials that cannot be cleaned are removed from the building in sealed impermeable plastic bags. These materials may be disposed of as ordinary waste.

8) The work area and surrounding areas should be HEPA vacuumed and cleaned with a damp cloth or mop and a detergent solution.

9) All areas should be left dry and visibly free from contamination and debris.

10) Note: If abatement procedures are expected to generate a lot of dust (e.g., abrasive cleaning of contaminated surfaces, demolition of plaster walls) or the visible concentration of the mold is heavy (blanket coverage as opposed to patchy), it is recommended that the remediation procedures for Level IV be followed.

d. Level IV: Extensive Contamination (greater than 100 contiguous square feet in an area).

i. Industrial hygienists or other environmental health and safety professionals with experience performing microbial investigations and/or mold remediation should be consulted prior to remediation activities to provide oversight for the project. The following procedures may be implemented depending upon the severity of the contamination:

1) Personnel trained in the handling of hazardous materials and equipped with:

a) Full face piece respirators with HEPA cartridges, disposable protective clothing covering entire body including both head and

shoes and gloves.

2) Containment of the affected area: Complete isolation of work area from occupied spaces using plastic sheeting and sealed with duct tape (including ventilation ducts/grills, fixtures, and other openings). The use of exhaust fan with HEPA filter to generate negative pressurization. Airlocks and decontamination room.
3) Removal of infants, persons having undergone recent surgery, immune-suppressed people, or people with chronic lung disease ie: asthma, hypersensitivity pneumonitis and severe allergies is recommended from surrounding work areas. All others may not need to be moved if contaminant practices effectively prevented mold from migrating from affected area.
4) Contaminated materials that cannot be cleaned should be removed from the building in sealed impermeable plastic bags. The outside of the bags should be cleaned with a damp cloth and a detergent solution or HEPA vacuumed in the decontamination chamber prior to their transport to uncontaminated areas of the building. These materials may be disposed of as ordinary waste.
5) The contained area and decontamination room should be HEPA vacuumed and cleaned with a damp cloth or mopped with a detergent solution and be visibly clean prior to the removal of isolation barriers.

5. Personal Protective Equipment (PPE)
   a. Gloves are used to protect the skin from contact with mold and disinfecting agents. Long gloves that extend to the middle of the forearm are recommended.
   b. Eye Protection:
   To protect your eyes, use properly fitted goggles or a full face piece respirator. Goggles must be designed to prevent the entry of dust and small particles. Safety glasses or goggles with open vent holes are not appropriate in mold remediation.
   c. Respiratory Protection - N-95 disposable respirators are available for use during Level I through Level III remediation procedures. It is recommended that during Level IV remediation procedures utilize PAPR units.
   d. Protective Clothing
   e. Disposable PPE should be discarded after it is used. They should be placed into impermeable bags, and usually can be discarded as ordinary construction waste.
6. Sampling for Mold - Air sampling is not a necessary part of a routine assessment because decisions about appropriate remediation strategies often can be made on the basis of a visual inspection. The Medical Director of Infection Prevention and Control will be consulted when air sampling is considered.
7. Moisture Meters - Moisture meters measure/monitor moisture levels in building materials, and may be helpful for measuring the moisture content in a variety of building materials following water damage. Moisture content $\leq$ 20% as determined by moisture meter readings is considered to be acceptable.

D. **REFERENCE(S)**:

1. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2003.(Updated July 2019, **Accessed 4/18/2023**)
2. CDC: Mold https://www.cdc.gov/mold/default.htm (accessed ~~5-6-2020~~**4/18/2023**)
3. ASHRAE: Position Document on Limiting Indoor Mold & Dampness in Buildings: June 27, 2018

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 09/11	**SUBJECT:** Credentialing Criteria, Cardiac Rehab (Outpatient)
REVISION DATE~~(S)~~: 09/11, 07/17	**POLICY NUMBER:** 8710 – 564

Medical Staff Department Approval:	~~02/20~~06/23
Credential Committee Approval:	~~03/20~~06/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~06/23
Administration Approval:	~~04/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. To provide criteria for use in credentialing physicians who request privileges in cardiac rehabilitation at the centers located at 4002 Vista Way, Oceanside and at 6250 El Camino Real, Carlsbad.

B. **INITIAL CREDENTIALING:**

1. Board certified by the American Board of Cardiology, American Board of Internal Medicine, American Board of Family Practice or the American Board of Emergency Medicine; or completion of an ACGME-approved residency in Cardiology, Internal Medicine, Family Medicine or Emergency Medicine;
2. For non-cardiologists, experience in cardiovascular care;
3. Current ACLS certificate or experience and knowledge in emergency procedures.

C. **PRIVILEGE AND PROCTORING REQUIREMENTS:**

PRIVILEGE	PROCTORING	REAPPOINTMENT
Consultation, cardiac rehab locations	2	10

D. **ONGOING PROFESSIONAL PRACTICE EVALUATION:**

1. Cases will be reviewed on an ongoing basis and reported to the practitioner's primary department/division with the goal of patient safety and successful performance of the procedure(s).

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Chronic Non Healing Wound Care
REVISION DATE~~(S)~~: 03/07~~,~~, 03/10~~,~~, 07/11~~,~~, 07/12 04/17, 04/20	**POLICY NUMBER:** 8710 – 523

Medical Staff Department Approval:	~~02/20~~06/23
Credentials Committee Approval:	~~02/20~~06/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~06/23
Administration Approval:	~~04/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. The following sites have been designated as locations with adequate resources to allow the performance of the designated privileges:
   a. 6260 El Camino Real, Carlsbad California
   b. 4002 Vista Way, Oceanside, California

B. **POLICY:**

1. Physicians/Allied Health Professionals/podiatrists who request wound care privileges must work within their scope of practice (*Podiatrists scope of practice means foot and ankle only) and shall demonstrate the ability to care for chronic non-healing wounds, including but not limited to: pressure, diabetic, venous, arterial, collagen vascular, autoimmune, and oncologic, and provide assessment and evaluations for patients with chronic non-healing wounds inclusive of:
   a. Routine review of patient record and recent labs
   b. Physical examination of all patient's bony prominences for evidence of excessive pressure or skin breakdown
   c. Determination of the number of observed chronic non-healing wounds and definition of their acuity
   d. Evaluation and management of any medical problems that would prevent wound healing
   e. Development of a treatment plan that facilitates wound healing
2. Physicians/Allied health Professionals/podiatrists shall be knowledgeable and capable of managing:
   a. Wound colonization and infection
   b. Appropriate antibiotics usage
   c. Prescription of needed support surfaces
   d. Advisement on off-loading techniques
   e. Enzymatic, mechanical and sharp debridement
   f. Wound biopsy techniques
   g. Pain management
   h. Indications for the use of adjunctive chronic wound care therapy such as, but not limited to: Vacuum Assisted Closure Devices, Collagen Matrix Implants, Platelet Derived Growth Factor, Oxidized Regenerated Cellulose, Living Dressings, Selective Impedance Electrical Stimulation and other adjunctive therapy which may, from time to time, become available.
   i. Referrals - demonstrate proficiency in knowing when and to whom to refer a patient

requiring specialized care outside of his/her area of expertise.

C. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following: Orthopedic Surgery, General Surgery, Vascular Surgery, Plastic Surgery or possess Board Certification in Podiatric Medicine.
   b. Non-Surgeon: The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Interventional Cardiology, Interventional Radiology, a fellowship in a field that includes the care of wounds, or completion of applicable course work within specified time frame.
   c. Allied Health Professionals: The applicant must be licensed by the Physician Assistant Board of California and have completed hands-on training that includes the care of wounds or completion of applicable course work within specified time frame.
2. Proctoring Criteria:
   a. Non-Surgeon: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at Tri-City Healthcare District (TCHD) or at another Joint Commission-approved facility.
   b. Allied Health Professionals: The proctoring of five (5) cases of debridement must be done by a physician or surgeon who routinely performs unsupervised debridement at TCHD or at another Joint Commission-approved facility.
   c. Surgeon: Does not require proctoring.
3. Reappointment Criteria:
   a. Twenty (20) documented procedures of chronic wound care per two-year reappointment cycle.
   b. Physician/Allied Health Professionals- specific quality data outcomes for reappointment time frame as defined by the Chronic Wound Care Program. If a physician's wound healing outcomes, healing rates and debridement rates fall below the 65th percentile success rating, his/her reappointment shall then be based on a thorough review of his or her performance by physician(s) who hold unsupervised wound care privileges and compliance with any and all recommendations arising from that review.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/07	**SUBJECT:** Credentialing Criteria, Hyperbaric Medicine Oxygen Therapy
REVISION DATE~~(S)~~: 03/07, 03/11, 01/12, 07/12, 12/13 04/17, 04/20	**POLICY NUMBER:** 8710 – 523A

Medical Staff Department Approval:	~~02/20~~06/23
Credentials Committee Approval:	~~02/20~~06/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~06/23
Administration Approval:	~~04/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. The following sites have been designated as outpatient chronic non-healing wound care centers ("WCCs") with adequate resources to allow the performance of the designated privileges:
   a. 6260 El Camino Real, Carlsbad, California
2. The following criteria shall be used in credentialing physicians who request privileges for Hyperbaric Medicine Oxygen Therapy in the WCCs.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. M.D., D.O., or DPM
   b. The applicant must have completed an ACGME accredited residency program in one of the following areas: Family Practice, Internal Medicine, Infectious Disease, Emergency Medicine, Physical Medicine and Rehabilitation, Orthopedic Surgery, Interventional Cardiology, Interventional Radiology, General Surgery, Vascular Surgery, Plastic Surgery, or hold a license to practice Podiatric Medicine.
   c. The applicant must have malpractice insurance that includes coverage for hyperbaric medicine.
   d. In addition to the above, the applicant must have one of the following:
      i. Completion of a Residency or Fellowship Training in hyperbaric medicine.
      ii. Completion of a hyperbaric medicine Training course approved by the American College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS)
      iii. Certified by the American Board of Preventive Medicine or the American Board of Emergency Medicine, in the subspecialty of Undersea and Hyperbaric Medicine.
   e. If more than two years has elapsed since completion of training, documentation of a minimum of sixteen (16) hours of CME related to hyperbaric medicine must be submitted.
2. Proctoring Criteria:
   a. A TCMC physician with unsupervised privileges in hyperbaric medicine, or a physician who holds hyperbaric medicine privileges at another Joint Commission-approved facility will proctor the first five (5) hyperbaric medicine therapy consults for practitioners with newly approved hyperbaric medicine privileges.
3. Reappointment Requirements:
   a. A minimum of sixteen (16) hours of CME related to hyperbaric medicine must be documented per two-year reappointment cycle. Half of this requirement can be met by

reading hyperbaric literature, with the rest being fulfilled through attending meetings and making presentations on hyperbarics.

b. Hyperbaric Medicine Oxygen Therapy: twelve (12) documented cases per two-year reappointment cycle.

c. Physician specific quality outcome data will be evaluated on an on-going basis as defined in Medical Staff Policy #8710-509.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 06/08	**SUBJECT:** Credentialing Policy, Expedited Credentialing and Privileging Process
REVISION DATE~~(S)~~: 06/08; 03/14, 04/17, 04/20	**POLICY NUMBER:** 8710 – 550

Medical Staff Department Approval:	~~02/20~~06/23
Credentials Committee Approval:	~~02/20~~06/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~06/23
Administration Approval:	~~04/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE**:
1. An expedited Board of Directors approval process may be used for initial appointments, reappointments, and granting privileges when the Board of Directors is unable to meet and established criteria is met.
2. The Chief Executive Officer (CEO) or Chief Board of Directors or Designee shall be responsible for granting membership and privileges when the Chief of Staff or designee, Department Chair/Division Chief, Credentials Committee, and the Medical Executive Committee have recommended the applications for the expedited approval process.

B. **EXPEDITED PROCESS:**
1. Schedule for Initial Applications:
   a. All expedited initial applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Applications #8710-543.
2. Schedule for Reappointment Applications:
   a. All expedited reappointment applications will be processed as outlined in Medical Staff Policy, Credentialing Policy, Processing Medical Staff Reappointments #8710-548.

C. **POLICY:**
1. The Medical Executive Committee will determine which applications meet the expedited criteria.
   a. An applicant for privileges is ineligible for the expedited process if any of the following has occurred:
      i. The applicant submitted an incomplete application.
      ii. The applicant reports an unacceptable health status.
      iii. The Medical Executive Committee makes a final recommendation that is adverse or has limitations.
      iv. There is a current challenge or previously successful challenge to licensure or registration.
      v. The applicant has received an involuntary termination of medical staff membership at another hospital.
      vi. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
      vii. The Medical Staff determines there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
2. Each credentialing application will be considered on a case-by-case basis.

3. The expedited application/reappointment reports will be forwarded the following month as an informational agenda item to the Board of Directors.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**02/07**	**SUBJECT:**	**Credentialing Policy, Processing Medical Staff Applications**
REVISION DATE~~(S)~~:	**01/09~~;~~, 04/09~~;~~, 09/09~~;~~, 06/10~~;~~, 01/12~~;~~, 01/13; 03/13, 04/17, 04/20**	**POLICY NUMBER:**	**8710-543**

Medical Staff Department Approval:	**~~02/20~~06/23**
Credentials Committee Approval:	**~~02/20~~06/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~06/23**
Administration Approval:	**~~04/20~~08/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaw requirements.
   a. If the Medical Staff determines during the review process that more information is required to complete an applicant's application, the applicant shall be notified immediately to provide additional documentation and the application shall be deemed incomplete until such information is received and the Medical Staff considers the application complete.

B. **POLICY:**

1. Applications shall be processed in accordance with the timeframes set by the Medical Staff Bylaws to the extent possible.
2. Each individual medical staff member or applicant shall have a separate credentials file.
3. Telemedicine applicants shall be fully privileged and credentialed according to Tri-City Healthcare District (TCHD) Medical Staff policies, rules and regulations, and bylaws.
4. The applicant's ability to perform privileges requested shall be evaluated and documented in the applicant's credentials file.
   a. If there is a concern about the applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required to ascertain that the applicant can perform the requested privilege(s).
5. Requests for peer recommendations should address the following competencies:
   a. Medical/Clinical knowledge
   b. Technical and clinical skills
   c. Clinical judgment
   d. Interpersonal skills
   e. Communication skills
   f. Professionalism
   g. Ability to perform the requested privilege (e.g., physical and mental health status)
6. Requests for verification of internship, residency, fellowship, hospital affiliations and employment verification should address the following competencies:
   a. Patient care
   b. Medical/Clinical knowledge
   c. Practice-Based learning and improvement

d. Interpersonal and communication skills
e. Professionalism
f. Systems-based practice

7. The following Joint Commission/CMS approved primary source verification sources shall be utilized:

Item Requiring Primary Source Verification	The Joint Commission/CMS Approved Verification Source
i. Medical education	AMA or AOA Physician Masterfile, ECFMG certificate for foreign medical schools, or directly from source.
ii. Postgraduate Training (Internship, residencies, fellowships)	AMA or AOA Physician Masterfile, or directly from source.
iii. Board Certification	ABMS or services designed by ABMS as an official display agent.
iv. Current Licensure	Directly from state licensing board. LVS system or the Osteopathic Medical Board of California for any 805 reports.
v. Sanctions against licensure	Directly from the state Medical Boards and/or National Practitioner Data Bank (NPDB).
vi. Peer Recommendation/Current Competence	Peer Reference forms that include the six areas of "General Competencies." Directly from the peer reference provided by the applicant.
vii. Medicare/Medicaid Sanctions	NPDB, AMA/OIG, and SAM (System for Award Management)
viii DEA Certificate	National Technical Information Service (NTIS) website query or the Drug Enforcement Agency verification website

8. The following additional queries shall be performed:
   a. Criminal background check via contracted agency
   b. NPDB (Claims history, OIG)
   c. Hospital Affiliations/Medical Staff Membership (past and present)
      i. Telemedicine applicants – If more than 10 affiliations/medical staff memberships, randomly select ten (10) entities to query. If necessary, more entities may be queried.
   d. Work History (within the past five (5) years)
9. The applicant shall explain all time gaps greater than thirty (30) days in writing.
   a. If clinical privileges are being requested and a time gap away from medicine is identified, the Credentialing Specialist shall collect as much information as possible to assist the Medical Staff in making a determination of competence.
   b. If the applicant identifies an entity that can be queried to verify the gap, the Credentialing Specialist shall attempt to contact that source.
   c. If a gap of a year or longer away from the applicant's practice is identified, the applicant must provide documentation of medical practice activity and/or CME within two (2) years of the application date to determine the applicant's competency.
10. The applicant shall explain in writing any convictions or guilty pleas to a criminal offense (felony or misdemeanor other than minor traffic violations).
    a. The applicant shall be referred to the Physician Well-Being Committee for evaluation in cases when the applicant's conduct or substance use is in question. His/her application will not be considered complete until an initial evaluation is completed and reported to the Credentialing Specialist.
11. The applicant's identity shall be verified using the "Positive ID" form in accordance with The Joint Commission Standard MS.06.01.03 (EP 5). Appropriate identification includes a valid state-issued identification card, driver's license, or a valid military ID. (This element shall be completed onsite by an authorized individual prior to final approval. Verification of the identity of telemedicine practitioners who will not be entering the facility may be performed by a Joint

Commission accredited organization, with verification provided by the organization.)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 04/05	**SUBJECT:** Credentialing Standards for Vertebral Augmentation
REVISION DATE~~(S)~~: 05/11, 08/17, 08/20	**POLICY NUMBER:** 8710-534
Department Approval:	~~05/20~~06/23
Credentials Committee Approval:	~~06/20~~06/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/20~~06/23
Administration Approval:	~~08/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in vertebral augmentation procedures:
   a. Didactic education in the diagnosis and treatment of patients with spine fractures and or deformity of the spine resulting from osteoporosis or tumors;
   b. Training in the technical aspects of the performance of vertebral augmentation;
   c. Proctoring;
   d. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. The applicant must be either an MD or DO.
   b. The applicant must have completed an ACGME/AOA-accredited residency program and possess board certification or board eligibility in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology and one of the following:
      i. Fellowship Training in Spine Surgery or Interventional Radiology or;
      ii. Current Competence* in spine surgery or interventional spine procedures (*provide documentation of ten (10) cases in past two years, without significant complications)
   c. The applicant must be trained in fluoroscopy and have a valid Fluoroscopy Supervisor and Operator permit.
   d. The applicant must have completed training in vertebral augmentation. Evidence of this training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.
2. Proctoring Criteria:
   a. Five (5) cases performed during the first two year appointment will be proctored by a member of the TCMC Medical Staff with unsupervised vertebral augmentation privileges.
3. Reappointment Criteria:
   a. Five (5) vertebral augmentation procedures annually performed during the reappointment cycle (10 cases total) with acceptable success and complication rates (Refer to Possible Complications for Vertebral Augmentation).

C. **REFERENCE(S):**

1. Clinical Privilege White Paper: Procedure 201, Balloon Kyphoplasty;
2. Clinical Privilege White Paper: Procedure 30, Percutaneous Vertebroplasty
3. Palomar Hospital Privileging Criteria for Percutaneous Vertebroplasty and/or Balloon Assisted Vertebroplasty (Kyphoplasty)

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

1. Possible Complications for Vertebral Augmentation

Possible Complications for Vertebral Augmentation:

1. Clinical Complications:
   a. Death (0%)
   b. Permanent (duration > 30 days) neurological deficit (other than radicular pain):
      1) Osteoporosis (0%)
      2) Neoplasm (5%)
   c. Transient (duration < 30 days) neurological deficit (other than radicular pain) or radicular pain syndrome (either permanent or transient):
      1) Osteoporosis (5%)
      2) Neoplasm (10%)
   d. Symptomatic pulmonary cement embolus (0%)
   e. Symptomatic epidural venous cement embolus (5%)
   f. Infection (0%)
   g. Fracture of rib or vertebrae (5%)
   h. Significant hemorrhage or vascular injury (0%)
   i. Allergic or idiosyncratic reaction (1%)

2. Technical/Procedural Complications:
   a. Failure to obtain proper informed consent (0%)
   b. Cement embolus to pulmonary vasculature without clinical sequela and estimated volume > 0.25 ml (5%)
   c. Cement embolus to epidural veins without clinical sequela and producing > 10% spinal canal compromise or estimated volume > 0.25 ml (10%)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 10/04	**SUBJECT:** Election Process of Member(s) at Large for the Medical Executive Committee
REVISION DATE~~(S)~~: 04/08, 08/12, 09/17, 08/20	**POLICY NUMBER:** 8710 – 531

Department Approval:	~~07/20~~06/23
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/20~~06/23
Administration Approval:	~~08/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**

1. To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

B. **PROCEDURE:**

1. All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
2. Interested Active Medical Staff members are required to complete a Conflict of Interest form before being added to the ballot.
3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
4. Voting will be by **secret** ballot.
5. A quorum of voting members is required to elect Members-at-Large.
6. Each voting member will be allotted **one**~~two~~ votes. ~~A member may vote twice for any one candidate or vote once for any two candidates or withhold one or both votes.~~
7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
   a. If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
8. Vacant seat(s) after original appointment on the Medical Executive Committee shall remain vacant until the next June General Medical Staff Meeting.
9. Members-at-Large will serve a two year term and no member shall serve more than two successive terms.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09 **SUBJECT:** Age Appropriate Care

REVISION DATE~~(S)~~: 11/12, 1/13, 03/20

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~03/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/20

A. **PURPOSE:**

1. All employees shall demonstrate the skills and knowledge required to provide age specific care for patients and their caregiver/family in the perioperative setting.

B. **POLICY:**

1. Educational content including the principles of growth and development over the life span served by Tri-City Medical Center department of Surgery shall be provided during orientation.
2. Reviews of the knowledge and skills necessary for required age specific care shall be provided annually via a Net Learning module and exam.
3. Knowledge, skill base and ability to provide care appropriate to the patients served on the unit shall be evaluated during orientation, and at each annual performance review.
4. Employees shall include family/caregiver as appropriate in meeting age specific needs of the patient.
5. Plans of care shall be modified to meet age specific physiological, psychological, and the social needs of the patient.
6. The guidelines for age specific care shall be followed for planning, implementation, and evaluation of patient care.
7. Age appropriate medication dosages, therapeutic ranges and age specific laboratory values can be obtained from the pharmacy and laboratory departments as needed.
8. Additional guidelines for care of patients with age-associated illness, physical limitations and needs are obtainable from the education department.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Physician Orders**

REVISION DATE~~(S)~~: 09/20

Wound Care Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	~~05/20~~05/23
Medical Executive Committee Approval:	~~08/20~~06/23
Administration Approval:	~~09/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/20

A. **PURPOSE:**

1. This policy defines the circumstances in which a physician's orders – verbal, telephone or written – will be accepted and implemented by the clinical staff.

B. **POLICY:**

1. Only physicians/healthcare professionals granted hospital and wound care & hyperbaric medicine medical staff privileges may provide written, telephone or verbal orders for patients being seen at the Center.
2. The clinical staff will take orders only from the Center staff physicians.
3. Any treatment/procedure may not be performed without the physician's written, verbal or telephone instruction unless defined by policy and/or falls within the scope of nursing practice, as mandated by the State of California.
4. Orders for patients not being seen by the physicians at the Center may not be accepted or implemented by the clinical staff.
5. Hospital policy will be followed when implementing physician's orders.

C. **PROCEDURE:**

1. When the physician is on site, orders will be **electronically entered**~~written~~ and signed by the physician after each clinic visit.
2. Verbal orders are discouraged but may be taken by the licensed clinical staff at the direction of the clinic physician caring for the patient.
3. Physicians must sign telephone or verbal orders within the timeframe specified in the hospital Medical Staff Bylaws and application regulations/standards.
4. All physician orders will be noted by a **licensed nurse**~~registered nurse/PT~~ according to hospital policy.

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

1. Patient Care Services Policy: Physician / Allied Health Professionals (AHP) Orders for Outpatient Services

Tri-City Health Care Distri
Oceanside, California

RETIRE follow Administrative Policy: New Hire and Department Specific Orientation

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Unit Specific Orientation

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

Department Approval:	~~02/20~~06/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~08/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

~~A. PURPOSE:~~

~~1. Because of the complexity of the services offered, comprehensive orientation to the processes and protocols of the wound care and hyperbaric medicine center is essential to adequately prepare associates to work in this new environment. This document delineates the responsibilities of the hospital, the wound care center and the associate and defines the processes necessary for equipping each employee to safely/effectively perform his/her job duties.~~

~~B. RESPONSIBILITY:~~

~~1. The hospital assumes responsibility for the initial and annual orientation programs.~~
~~2. The department is responsible for the unit-specific orientation, the unit-specific safety and environment of care training and for staff development programs throughout the year that meet the identified needs of the staff and the clinic operations.~~
~~3. The clinic manager assumes overall responsibility for the design, implementation and evaluation of the orientation process.~~
~~4. The associate, in partnership with the hospital, assumes responsibility for:~~
~~a. Professional education/licensing and certifications~~
~~b. Identifying their own learning needs~~
~~c. Pursuing opportunities to meet their learning needs~~

~~C. POLICY:~~

~~1. All employees joining the clinic team will have a unit-specific orientation and training.~~
~~2. The orientation/training content will be current, applicable and systematic.~~
~~3. The orientation/training experience is individualized and designed to provide pertinent policy and procedural knowledge to be followed by the new associate.~~
~~4. Instruction will be clear, succinct and administered at the level of the learner.~~
~~5. Competency assessments, where applicable, will be completed before the end of the unit orientation and filed in the associate employment folder in the HR department.~~
~~6. Orientation will be provided during the associates assigned work shift.~~
~~7. Instruction will be didactic and experiential.~~
~~8. Orientees will be acquainted with their new surroundings and receive sufficient orientation and training to become a member of wound care team.~~
~~9. Cross training of an associate may also occur when appropriate. The training will be sufficient in content and duration to prepare the associate for their new position.~~

~~D. PROCEDURE:~~

1. ~~All associates will receive general hospital orientation.~~
2. ~~Department-specific orientation and training will occur in the initial period of the associate's employment and prior to taking full responsibility for their assigned duties.~~
3. ~~A job description will be given to each orientee.~~
4. ~~The duration of the orientation period will be sufficient to prepare the employee for full participation in clinic activity.~~
5. ~~Each new staff member will be assigned to a resource person(s) by the clinic manager.~~
6. ~~During the 90-day initial employment period, the new employee will be observed by the clinic manager and/or designee for progress, and adjustments to the training will be made accordingly.~~
7. ~~Department-specific orientation schedule includes:~~

E. ~~**ALL CENTER STAFF MEMBERS:**~~
1. ~~Job descriptions~~
2. ~~Safety~~
   a. ~~Safety Data Sheets (SDS)~~
   b. ~~Emergency plans (fire, disaster, etc.)~~
   c. ~~Hazardous waste~~
3. ~~Infection Control~~
   a. ~~Standard (Universal) precautions~~
   b. ~~Personal protective equipment~~
   c. ~~Biohazardous waste~~
   d. ~~Handwashing~~
4. ~~Review of abuse reporting policy~~
5. ~~Performance improvement program~~
6. ~~Risk management program~~

F. ~~**CLINICAL STAFF ORIENTATION:**~~
1. ~~Unit orientation~~
2. ~~Clinic policies and procedures~~
3. ~~Clinic flow~~
4. ~~Equipment~~
   a. ~~Doppler~~
   b. ~~Glucometer~~
   c. ~~Photography~~
5. ~~Case management (RN)~~
6. ~~Blood drawing/transporting/storage techniques~~
7. ~~Medical records/documentation~~
8. ~~Supplies/Protective devices~~

G. ~~**MEDICAL STAFF:**~~
1. ~~Unit orientation~~
2. ~~Clinic flow~~
3. ~~Medical records/documentation~~
4. ~~Dictation~~
5. ~~Supplies/protective devices~~

H. ~~**SUPPORT STAFF:**~~
1. ~~Unit orientation~~
2. ~~Clinic flow~~
3. ~~Medical Records~~
4. ~~Data base~~

~~5. Billing/Reimbursement/Registration~~
~~6. Phone techniques/etiquette~~
~~7. Equipment~~
~~a. Copier~~
~~b. Fax~~
~~c. Computer/printer~~

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

June 21, 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 June 6, 2023.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director George W. Coulter

Also present were:

Dr. Gene Ma, Interim Chief Executive Officer
Ray Rivas, Chief Financial Officer
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger 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 Sanchez to approve the agenda as presented. The motion passed (6-0-0-1) with Director Coulter absent.

3. Consideration to appoint Chairperson/Vice Chairperson positions.

   Board Counsel stated that Chairperson Chavez has decided to step down and therefore the Board must select a new Chairperson.

   It was moved by Director Sanchez to appoint Director Younger to the office of Chairperson. Director Gleason seconded the motion. The motion passed (6-0-0-1) with Director Coulter absent.

   In light of the fact that Director Younger would be moving up to the Chairperson position, Director Younger moved to appoint Director Chaya as Vice Chairperson. Director Gleason seconded the motion. The motion passed (6-0-0-1) with Director Coulter absent.

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

Board Counsel Jeff Scott made an oral announcement of the items listed on the June 21, 2023 Special Board Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: Vice President/Human Resources and Reports Involving Trade Secrets.

4. Motion to go into Closed Session

It was moved by Director Sanchez and seconded by Director Gleason to go into Closed Session in accordance with the items listed on the June 21, 2023 agenda. The motion passed (6-0-0-1) with Director Coulter absent.

5. At 5:55 p.m. the Board returned to Open Session with Directors Chavez and Coulter absent.

6. Report After Closed Session

Board Counsel Jeff Scott reported that the Board in Closed Session heard Reports Involving Trade Secrets and took no action.

The Board in Closed Session also discussed the Vice President of Human Resources position and took no action.

7. New Business

a) Review, discussion and action regarding the Operating and Capital Budgets for FY 2024.

Ray Rivas, CFO provided an overview of the FY2023 and the projected FY 2024 operations budgets. Key indicators were reviewed, including Average Daily Census, Average Length of Stay and Discharges. Mr. Rivas also reviewed the Financial Statements for FY 2023, the projected Financial Statements for FY 2024, the Gross Revenues and Expenses as well as hospital Assets and Liabilities. Mr. Rivas also reviewed the proposed Capital Budget for FY 2024. He noted an EROE loss of $30 million. The proposed budget for FY 224 reflects a turnaround of approximately $20 million which will result in a positive EBITDA of $4.2 million. This will be accomplished through increases in revenue, new contracts, improving our clinics as well as new rates. With regard to expenses, the biggest component is contract labor, salaries and increased pharmacy expenses.

Following discussion, the vote on the motion was as follows:

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

8. Adjournment

Hearing no further business Chairperson Younger adjourned the meeting at 6:01 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
June 29, 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 June 29, 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 Gigi Gleason
Director George W. Coulter
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

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

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

2. Approval of Agenda

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

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Younger read the Public Comments section listed on the June 29, 2023 Regular Board of Directors Meeting Agenda. She asked that members of the public wishing to speak submit a speaker card at this time.

76. May, 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 – $299,390
- Operating Expense – $333,594
- EBITDA – ($12,029)
- EROE – ($25,211)

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

- Average Daily Census – 118
- Adjusted Patient Days – 78,835
- Surgery Cases – 4,941
- ED Visits – 49,583

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

- Net Operating Revenue – $27,458
- Operating Expense – $31,906
- EBITDA – ($2,549)
- EROE – ($3,739)

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

- Average Daily Census – 108
- Adjusted Patient Days – 6,703
- Surgery Cases - 452
- ED Visits – 4,626

Mr. Rivas reported at last week's Special Board Meeting the FY2024 budget was presented and approved by the Board which projects a $20 million turnaround. Changes have been implemented and are ongoing to meet this goal.

Mr. Rivas commented on the importance of our length of stay (LOS) which is a key indicator for a positive bottom line. He congratulated the team on getting the LOS down to 4.6 for the month of May.

7. New Business –

Consideration to approve the Chief Executive Officer agreement with Dr. Gene Ma.

It was moved by Director Gleason to approve the Chief Executive Officer agreement with Dr. Gene Ma. Director Sanchez seconded the motion.

The vote on the motion was as follows:

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

ABSENT: Directors: None

Chairperson Younger congratulated Dr. Ma on his appointment to permanent CEO of Tri-City Medical Center.

8. Old Business – None

9. Chief of Staff –

a) Consideration of June 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 26, 2023.

Dr. Henry Showah, Chief of Staff presented the June 2023 Credentialing Actions and Reappointments Involving the Medical Staff. No concerns or "red flags" were raised by the Credentials Committee.

Dr. Showah stated he enjoys a strong loyal base of physicians as well as the support of a strong Board and C-Suite. He congratulated Director Younger and Director Chaya on their newly appointed positions as Chairperson and Vice Chair, respectively, as well as Dr. Ma on his appointment to the CEO role.

It was moved by Director Gleason to approve the June 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 26, 2023. Director Sanchez seconded the motion

The vote on the motion was as follows:

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

10. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Calendar as presented. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

11. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

12. Comments by Members of the Public

There were no comments from members of the public.

13. Comments by Chief Executive Officer

Dr. Gene Ma, Chief Executive Officer thanked the Board for the confidence they have expressed in him. He stated he is incredibly proud of the way our nursing teams, our leaderships teams, and our employees across the organization have rallied together to help us move forward to achieve our goals.

Dr. Ma acknowledged the Auxiliary who had their annual Installation of Officers ceremony. He thanked Linda Wolfe who served as the President for the last two years during a challenging time and congratulated Bunny McElliott who will assume the role of President. Dr. Ma also presented a check that the hospital received from the Auxiliary in the amount of $40,000 and expressed his appreciation.

Dr. Ma commented on the new MRI which is projected for completion in early fall. The 3.0T MRI will reimagine what high level MRI imaging can be done in north county.

Dr. Ma also commented on the temporary triage construction unit that was custom built and installed recently in anticipation of our ER remodel. Dr. Ma expressed his appreciation to our Foundation is who is at the forefront of both of these projects.

Lastly, Dr. Ma commented on an article that appeared in the UT and other media outlets which is a story of a 67-year-old husband that was resuscitated here at Tri-City after 70 minutes of CPR which means the likelihood of survival with meaningful neurologic outcomes is less than 1%. Dr. Ma stated the resuscitation, the algorithms, the treatments, the providers in the ER, ICU, our nurses, our techs and all of our staff are exceptional when called upon to deliver that level of care and he is very proud of those efforts.

14. Board Communications

Chairperson Younger extended her thanks to our past Board Chairman, Rocky Chavez for his exceptional leadership during the COVID 19 emergency and seeing us through the selection of a new CEO.

Chairperson Younger also recognized all of our workers -- the doctors, the employees, the volunteers who are the heartbeat of Tri-City.

Chairperson Younger congratulated and acknowledged our new CEO, Dr. Gene Ma for stepping into his new role with determination and vision. She thanked Dr. Ma for his leadership and his team for steering us through this transition.

Lastly, Chairperson Younger thanked the Board for entrusting her with this new position and their unwavering support as well as their collective wisdom and knowledge.

Director Sanchez commented on the positive energy coming out of the C-Suite. She congratulated Dr. Ma on his appointment to CEO and stated she believes seeing bedside providers in the CEO role is going to be the future.

Director Mizel stated he looks forward to the future and believes Dr. Ma will do a good job in his role as CEO. He expressed his confidence in Dr. Ma and his team.

Dr. Chaya congratulated Dr. Ma on his new role and stated she is pleased to see a physician taking on the role of CEO.

Director Coulter congratulated Dr. Ma on his new role.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:55. p.m. to return to closed session.

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

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

June 29, 2023 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on June 29, 2023.

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

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

Also present were:

Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 2:30 p.m. with attendance as listed.

2. Approval of Agenda

It was moved by Director Gleason and seconded by Director Coulter to approve the agenda as presented.

Board Counsel Jeff Scott made an oral announcement of the items listed on the June 29, 2023, Special Board Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets and Public Employee Appointment: CEO.

5. Motion to go into Closed Session.

It was moved by Director Gleason, seconded by Director Coulter, and unanimously carried (7-0) to go into Closed Session in accordance with the items listed on the June 29, 2023 agenda.

6. At 3:23 p.m. the Board returned to Open Session with attendance as previously noted.

7. Report After Closed Session.

Board Counsel Jeff Scott reported that the Board in Closed Session heard a report and discussed Trade Secrets in accordance with Government Code Section 32106 and took no action.

The Board in Closed Session also heard a report from the CEO and took no action.

8. Adjournment

Hearing no further business, Chairperson Younger adjourned the meeting at 3:25 p.m.

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

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

July 10, 2023 – 3:30 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 July 10, 2023.

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

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

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 3:00 p.m. with attendance as listed.

2. Approval of Agenda.

   Board Counsel Jeff Scott made an oral announcement of the items listed on the July 10, 2023, Special Board Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets and Public Employee Appointment: CEO.

5. Motion to go into Closed Session.

   It was moved by Director Gleason seconded by Director Coulter, and unanimously carried (7-0) to go into Closed Session in accordance with the items listed on the July 10, 2023 agenda.

6. At 5:05 p.m. the Board returned to Open Session with all Board members present with the exception of Director Mizell.

7. Report After Closed Session.

   Board Counsel Jeff Scott reported that the Board in Closed Session discussed Reports Involving Trade Secrets and took no action.

   The Board in Closed Session also heard a report from the CEO and took no action.

8. New Business

a) Consideration of Consulting Agreement with Steven Hollis

Board Counsel requested that the Board consider the Consulting Agreement with Steven Hollis, a copy of which will be kept for the record.

Following Board discussion, it was moved by Director Chavez, seconded by Director Gleason and carried (6-0-0-1), with Director Mizell absent, to approve the Consulting Agreement with Steven Hollis.

9. Adjournment

Hearing no further business, Chairperson Younger adjourned the meeting at 5:15 p.m.

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
July 27, 2023 – 5:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 5:00 p.m. on July 27, 2023.

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

Director George W. Coulter
Director Nina Chaya, M.D.
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director Rocky J. Chavez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Donald Dawkins, Interim CNE
Aaron Byzak, Chief External Affairs Officer
Jeremy Raimo, Sr. Director of Business Development
Quinn Abler, Assistant VP of HR
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 5:00 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Board Counsel Jeff Scott made an oral announcement of the items listed on the July 27, 2023 Special Board Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session in accordance with the items listed on the July 27, 2023 agenda. The motion passed (6-0-0-1) with Director Chavez absent.

5. At 7:00 p.m. the Board returned to Open Session with attendance as previously noted.

6. Report After Closed Session

Board Counsel Jeff Scott reported that the Board in Closed Session discussed Reports involving Trade Secrets and took no action.

7. Public Comments Announcement

Chairperson Younger read the Public Comments section listed on the July 27, 2023 Special Board of Directors Meeting Agenda. She asked that members of the public wishing to speak submit a speaker card at this time

8. New Business

a) Consideration and possible action regarding Women's & Newborn Services

Dr. Ma, Chief Executive Officer stated unfortunately, it has become clear that our solution for Women's & Newborn Services will require much more extensive due diligence and in the absence of an imminent solution, the administrative team must sadly recommend suspension of Women's & Newborn Services to include Labor & Delivery, post-partum and the NICU. Dr. Ma discussed the financial challenges we are faced with coupled with progressive loss of staff necessary to operate the units.

Chairperson Younger asked if there were any comments from members of the public. Hearing none:

It was moved by Director Chaya to suspend Women & Newborn Services. Director Gleason seconded the motion.

The vote on the motion was as follows:

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

b) Consideration to approve the 24-month cash flow analysis

Ray Rivas, CFO presented the 24-month cash flow analysis which is projected to improve the district next year by approximately $20 million with a $10 million loss. For FY 2025 we are projecting to break even with a positive EBITDA of $14 million. Mr. Rivas stated this will be accomplished through increases in revenue, new contracts, improving our clinics as well as improved HMO rates.

It was moved by Director Mizell to approve the 24-month cash flow analysis as presented. Director Gleason seconded the motion.

The vote on the motion was as follows:

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

c) Consideration to submit the application for the Distressed Hospital Loan Program, contingent upon final approval from Housing and Urban Development and ORX.

Dr. Ma explained that the state has set aside some funding to support hospitals as they recognize it is a challenging time for hospitals coming out of COVID. The proposed agenda item would allow Tri-City to submit an application for a portion of these funds.

It was moved by Director Mizell to approve submission of the application for the Distressed Hospital Loan Program, contingent upon final approval from Housing and Urban Development and ORX. Director Gleason seconded the motion.

The vote on the motion was as follows:

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

d) Consideration of a 12-year lease agreement with DISC Surgery Center, LLC for an ambulatory surgical center at the Wellness Center, contingent upon final approval from Housing and Urban Development and ORX.

Dr. Ma explained we are looking to deploy some of our assets and DISC Surgery Center supports our core services in a very complimentary fashion. The proposed agreement is a 12-year lease of over $10 million to the District. Dr. Ma noted many of the opportunities we are looking at do not have a significant cash outlay on behalf of the District upfront.

It was moved by Director Gleason to approve the 12-year lease agreement with DISC Surgery Center, LLC for an ambulatory surgical center at the Wellness Center, contingent upon final approval from Housing and Urban Development and ORX. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

e) Consideration to approve a cell tower rooftop assessment and assignment agreement with AP Wireless Investments, LLC, contingent upon final approval from Housing and Urban Development and ORX.

Dr Ma explained that we have a tower on our rooftop that is currently leased by two cellular entities. The proposed agreement with AP Wireless Investments, LLC would essentially lease out that asset in exchange for $1.3 million to the district.

It was moved by Director Coulter to approve a cell tower rooftop easement and assignment agreement with AP Wireless Investments, LLC, contingent upon final approval from Housing and Urban Development and ORX. Director Gleason seconded the motion.

The vote on the motion was as follows:

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

f) Consideration to approve the realignment of the C-Suite as recommended by Dr. Gene Ma, CEO.

Dr. Ma explained the realignment of certain C-Suite members, specifically, moving Jeremy Raimo into the position of Chief Operating Officer, Aaron Byzak to Chief Strategy Officer and Mark Albright to Chief Information Officer. Dr. Ma explained this is simply a realignment to reflect the roles these individuals have essentially taken on. Dr. Ma stated it is important to know there is no commensurate increase for these positions due to where we are today financially.

Chairperson Younger stated the Board truly appreciates the hard work Dr. Ma's team has been doing.

Chairperson Younger asked if there were any comments from the public. Hearing none:

It was moved by Director Mizell to approve the realignment of C-Suite as recommended by Dr. Gene Ma, CEO. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

9. Board Comments

Chairperson Younger stated it was an incredibly hard decision to decide to close Women & Newborn Services and the decision was made with heavy hearts. "The Board knows the significant impact the closure will have on expectant mothers and their families, as well as the dedicated staff who have worked tirelessly supporting the unit over the years. Director Younger also stated that the Board recognizes the vital role that the Labor & Delivery plays in ensuring safe and specialized care in pregnancy and childbirth and we deeply empathize with concerns and anxieties that this decision may raise within our community. The Board appreciates the support as we navigate through this very difficult

time and remain committed to finding a sustainable solution and exploring avenues for future reinstatement of these vital services".

10. Adjournment

Hearing no further business Chairperson Younger adjourned the meeting at 7:20 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY24	69.7												69.7	48-52
FY23	74.3	72.0	67.7	69.8	71.5	71.0	71.3	72.7	70.6	74.6	71.6		74.3	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY24	140.9												140.9	75-100
FY23	105.3	105.6	106.4	115.2	119.0	128.8	142.0	153.4	168.0	158.4	144.5		105.3	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	($3,585)												($3,585)	($3,834)
FY23	($1,651)	($1,599)	($2,185)	($1,358)	($1,812)	($2,028)	($532)	($1,051)	($2,982)	($6,274)	($3,739)		($1,651)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	-14.11%												-14.11%	-14.61%
FY23	-5.96%	-5.83%	-8.19%	-4.89%	-6.83%	-7.33%	-1.83%	-3.94%	-10.69%	-25.56%	-13.62%		-5.96%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	($2,442)												($2,442)	($2,631)
FY23	($686)	($205)	($987)	($175)	($594)	($781)	$605	$75	($1,648)	($5,086)	($2,549)		($686)	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	-9.61%												-9.61%	-10.03%
FY23	-2.48%	-0.75%	-3.70%	-0.63%	-2.24%	-2.82%	2.08%	0.28%	-5.90%	-20.72%	-9.28%		-2.48%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY24	6.12												6.12	6.69
FY23	6.53	5.91	5.93	6.48	7.13	7.14	6.35	5.96	6.12	6.30	7.10		6.53	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY24	$18.3											
FY23	$43.9	$38.1	$29.6	$25.3	$20.7	$22.5	$25.4	$11.4	$6.9	$27.7	$23.8	

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending July 31, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	53,103.84	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)	41,963.94	07/01/17	08/31/24	**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)	20,991.88	07/01/20	06/30/30	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 **V#84264**	Approx 2,460	$2.21	(a)	16,651.02	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)	15,377.32	09/01/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suit A Oceanside, CA 92058	7094
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,812.09	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)	32,633.00	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)	15,747.34	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)	19,683.38	07/01/17	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
Total				**252,261.73**				

(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 July 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	Charge	70623 EDU	200.00	32450	HERNANDEZ, ROBERT
8740	Charge	71423 EDU	126.00	46518	NANCE, LAUREN
8740	ASRT	71423 EDU	125.00	82014	O'GRADY, MAUREEN
8740	NAHQ MEMBERSHIP	70623 EDU	200.00	83899	KRAUS DANA
8740	MAMMO	70623 EDU	139.90	84157	STACIA ROBERTS
8740	DEATH AND BRAIN COURSE	72123 EDU	120.00	84293	LOCKHART JESSICA

**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.