TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 14, 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	Consideration to accept the fiscal year 2023-2024 Financial Statement Audit	15 min.	CFO
6	October 2023 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration and possible action to elect Board of Director Officers for calendar year 2024: 1) Chairperson 2) Vice Chairperson 3) Secretary 4) Treasurer 5) Assistant Secretary 6) Assistant Treasurer 7) Board Member b) Consideration of proposed 2024 Board Meeting Schedule c) Consideration to award a Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000	 10 min. 5 min. 10 min.	 Chair Chair Auxiliary President

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
8	Old Business – a) Affiliation Update – Information Only b) Consideration to approve Resolution 825, A Resolution of Tri-City Healthcare District, A Resolution of Tri-City Healthcare District Board of Directors Granting Signature Authority to the Chief Executive Officer during the Due Diligence Period	10 5 min.	CEO Board Counsel
9	Chief of Staff - a) Consideration of November 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 27, 2023.	5 min. .	COS
10.	Consent Calendar 1) Consideration to approve the Infection Preventionist appointments of Rabecka Moore, RN CIC and Fernando Rivera, MPH CIC per CMS Hospital Conditions of Participation (CoP) Section 482.42. 2) Consideration to approve Amendment #1 between Tri-City Healthcare District and North County Oncology Medical Clinic, Inc. to secure the professional services of Dr. Catherine Quinn for the clinic. 3) Consideration to authorize the advanced payment to Dr. Contardo as North Coast Pathology Medical Group (NCPMG) for Clinical & Anatomic Pathology Laboratory services for a term of 52 days, beginning November 9, 2023 and ending December 31, 2023, for a total cost of $156,000.00. 4) **Policies & Procedures** **A. Patient Care Services** 1. Cardiac Cath Lab Standardized Procedure 2. Chemotherapy Extravasation Procedure 3. Chemotherapy Patient Intake Procedure 4. Controlled Substances Management Policy 5. Dialysis, Acute Treatment of the Inpatient Policy 6. Disposal of Chemotherapy Waste Procedure 7. Haloperidol IV Administration Standardized Procedure 8. Hypoglycemia Management in the Adult Patient Standardized Procedure 9. Immediate Use Sterilization, Intraoperative 10. Medical Equipment Brought into the Facility Policy 11. Medication Reconciliation Policy 12. Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Standardized procedure 13. Organ Donation, Including Tissue and Eyes Policy 14. Pain Management Policy 15. Patient Safety Plan 16. Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure 17. Profend Standardized Procedure 18. RN Managed Urinary Catheter Removal Standardized Procedure 19. Transport/Transfer of Patients within the Facility Policy	10 min.	

	Agenda Item	Time Allotted	Requestor
	B. Cardiac Rehab 1. Contraindication to Cardiac Rehab Exercise 2. Exercise Prescription 3. Exercise Protocol, Phase II 4. Patient Enrollment **C. Environment of Care** 1. Fire plan (Code Red) 3005 2. Life Safety Management Plan **D. Infection Control** 1. Ebola Plan Policy 2. Prion Diseases: Transmissible Spongiform Encephalopathies IC C-5 **E. Medical Staff** 1. Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds 8710-522 2. Criteria Pain Management Privileges 8710-541 3. Physician/Podiatrist Surgical assistant 8710-536 4. Requests for New Privileges Technology New to TCHD 8710-526 **F. Pharmacy** 1. Pharmacy and Therapeutics Committee **G. Surgical Services** 1. Duodenoscope Sampling for Quality Control Culturing Procedure (5) Minutes a) Regular Meeting – October 26, 2023 (6) Meetings and Conferences – None (7) Dues and Memberships – None (8) Reports – (Discussion by exception only) a) Building Lease Report – (October, 2023) b) Reimbursement Disclosure Report – (October, 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	

	Agenda Item	Time Allotted	Requestor
17	Adjournment		

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2024

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

- January 25, 2024 (Last Thursday)
- February 29, 2024 (Last Thursday)
- March 28, 2024 (Last Thursday)
- April 25, 2024 (Last Thursday)
- May 30, 2024 (Last Thursday)
- June 27, 2024 (Last Thursday)
- July 25, 2024 (DARK)
- August 29, 2024 (Last Thursday)
- September 26, 2024 (Last Thursday)
- October 31, 2024 (DARK DUE TO NOVEMBER GENERAL ELECTION)
- November 14, 2024 (Second Thursday – Holiday Schedule)
- December 12, 2024 (Second Thursday – Holiday Schedule)

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

Proposed: December 14, 2023

RESOLUTION NO. 825

RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTIORS GRANTING SIGNATURE AUTHORITY TO THE CHIEF EXECUTIVE OFFICER DURING THE DUE DILIGENCE PERIOD

WHEREAS, **TRI-CITY HEALTHCARE DISTRICT** (the "District") is a California health care district duly organized and existing under the laws of the State of California, particularly the Local Health Care District Law, constituting Division 23 of the Health and Safety Code of the State of California, and more particularly, Health and Safety Code §§ 32000 et seq. (the "Law"); and

WHEREAS, on October 26, 2023 at a public meeting, the Board of Directors of the District passed a motion directing staff to take the steps necessary to effectuate an affiliation of the District with the University of San Diego Health through a Joint Powers Agreement; and

WHEREAS, the District and UCSD Health are conducting due diligence and negotiating the terms and conditions of a potential affiliation; and

WHEREA, the Board Chair has appointed an Ad hoc Committee, consisting of the Board Chair, Vice Chair and Director Sanchez to work with the Hospital Chief Executive Officer (CEO), Board Counsel, and District consultants in effectuating the affiliation; and

WHEREAS, during the due diligence and negotiation process, there may be instances when because of timing or other constraints, it will be necessary for the CEO as the representative of the District to execute certain documents to effectuate the affiliation process; and

WHEREAS, the Board of Directors desires to delegate the necessary signature authority to the CEO subject to advice and approval of the Ad hoc Committee and with the understanding that any and all definitive agreements and other documents ultimately approving the affiliation will be subject to the approval of the Board of Directors at a properly noticed public meeting.

NOW, THEREFORE, this Board of Directors of Tri-City Healthcare District does hereby resolve:

Section I. The foregoing recitals are true and correct.

Section 2. The CEO, during the due diligence period, is hereby authorized to execute the necessary documents on behalf of the District to effectuate the affiliation process, subject to advice and approval of the Ad hoc Committee and with the understanding that any and all definitive agreements and other documents ultimately approving the affiliation will be subject to the approval of the Board of Directors.

Section 3. This Resolution shall take effect immediately upon its adoption.

ADOPTED, PASSED AND APPROVED this 14th day of December, 2023, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:

NOES:

ABSTAIN/ABSENT:

By:_____
Chairperson, Board of Directors

ATTEST:

By:_____
Secretary, Board of Directors

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 27, 2023

INITIAL APPOINTMENTS: (Effective Dates 12/15/2023 -10/31/2025)

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 12/15/2023 through 10/31/2025:

- **COOPER, James MD/Radiology/(Blue Ocean Imaging)**
- **DAVIS, Demetrice MD/Teleradiology/(StatRad)**
- **FOOLADIAN, Siyavash MD/Anesthesiology/(Echo)**
- **MCKNIGHT, Braden MD/Orthopedic Surgery/(Ortho 1)**
- **NISSIM, Lahav MD/Teleradiology/(SHPS)**
- **PLOCH, Stefan MD/Teleradiology/(The Radiology Group)**
- **QUINN, Catherine MD/Oncology/(Medical Oncology Associates of SD)**
- **TOWNE, Brooke MD/Pain Medicine/(Pacific Pain Medicine)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
November 27, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2024 -12/31/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2024 through 12/31/2025, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **BARVALIA, Mihir, MD/Interventional Cardiology/Provisional**
- **BONOMO, Rica, MD/Emergency Medicine/Active**
- **BRION, Paul, MD/Rheumatology/Active**
- **CHAYA, Nina, MD/Anesthesiology/Refer and Follow**
- **FAKHRO, Sameeh, MD/Internal Medicine/Provisional**
- **GUERENA, Michael, MD/Urology/Active**
- **GUPTA, Anuj, MD/Pain Medicine/Refer and Follow**
- **HEIFETZ, Susan, MD/Internal Medicine/Refer and Follow**
- **MILLER, Donald, MD/Pediatrics/Active**
- **NAGHI, Jesse, MD/Interventional Cardiology/Provisional**
- **PADILLA, Patrick, MD/Orthopedic Surgery/Provisional**
- **PEREIRA, Isabel, MD/Internal Medicine/Active**
- **SHEREV, Dimitri, MD/Interventional Cardiology/Provisional**
- **SHUEN, Jessica, MD/Emergency Medicine/Active**
- **STERN, Mark, MD/Neurological Surgery/Active**
- **THALKEN, Gregory, MD/Teleradiology/Active Affiliate**

Attachment B

RESIGNATIONS:

Voluntary:

- **BARCARSE, Erin, MD/Obstetrics & Gynecology**
  Resignation effective 10/25/2023.

- **CAMPBELL, Leticia, MD/Obstetrics & Gynecology**
  Resignation effective 11/06/2023.

- **DANQUAH, Vanessa, MD/Telepsychiatry**
  Resignation effective 11/01/2023.

- **FURUBAYASHI, Jill, MD/Teleradiology**
  Resignation effective 10/08/2023.

- **KABACKA, Julia, MD/Obstetrics & Gynecology**
  Resignation effective 12/31/2023.

- **MORRIS, Jeffrey, MD/Ophthalmology**
  Resignation effective 11/01/2023.

- **RICE, Katherine MD/Obstetrics & Gynecology**
  Resignation effective 12/31/2023.

- **ROTUNDA, Edward, MD/Emergency Medicine**
  Resignation effective 12/31/2023.

- **SHARMA, Anjali, MD/Obstetrics & Gynecology**
  Resignation effective 10/17/2023.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 27, 2023

PROCTORING RECOMMENDATIONS

- **COOPERMAN, Andrew, MD** — **Orthopedics**
- **JUAREZ, Veronica, MD** — **Emergency**
- **PASHA, Sabiha, MD** — **Internal Medicine**
- **VISEROI, Marius, MD** — **Pulmonary**

Tri-City Medical Center

December 4, 2023

Tri-City Healthcare District Board of Directors
4002 Vista Way
Oceanside, CA 92056

Re: Infection Preventionist Appointments

Dear Board of Directors:

Per CMS Hospital Conditions of Participation (CoP), Section 482.42, the governing body is responsible for the appointment of the Infection Preventionis(s) of the hospital as recommended by the Medical Staff Leadership and Nursing Leadership.

By way of this letter, we, Henry F. Showah, M.D., Chief of Staff (COS) and Donald A. Dawkins, RN, Chief Nurse Executive (CNE) hereby recommend approval of the appointments of Rabecka Moore, RN CIC and Fernando Rivera, MPH CIC by the Tri-City Healthcare District Board of Directors.

Respectfully,

Henry F. Showah, M.D.| Chief of Staff

Donald A. Dawkins, RN BS, BSN, MBA| CNE

Approved by the Tri-City Healthcare Board of Directors this 14th day of December, 2023.

Tracy M. Younger, Chairperson

ATTEST:_____

Gigi Gleason, Secretary

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 14, 2023
PROFESSIONAL SERVICES AGREEMENT: North County Oncology Medical Clinic, Inc. – Addendum One adding Catherine Quinn, M.D.

Type of Agreement		Medical Directors		Panel	X	Other: Addendum 1
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: **North County Oncology Medical Clinic, Inc. – Catherine Quinn, M.D.**

Area of Service: Hematology/Oncology

Term of Agreement: 12 months, Beginning January 1, 2024 through December 31, 2024

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

Terms of the Engagement:	**Proposal Costs:**
Monthly Professional Stipend	1 day/week: $7,500; 2 days/week: $15,000; 3 days/week: $22,500; 4 days/week: $30,000
Monthly Benefit Stipend	1 day/week: $920; 2 days/week: $1,840; 3 days/week: $2,759; 4 days/week: $3,679
Total Amount of Request:	**Not to Exceed: $404,148**

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/ Dr. Gene Ma, CEO.

Motion:

I move that the TCHD Board of Directors authorize through a Professional Services Agreement Amendment One (1) with North County Oncology Medical Group, Inc. for adding Catherine Quinn, M.D. for a term of 12 months to provide Professional Services at North County Oncology, Inc starting January 1, 2024 and ending December 31, 2024. Not to exceed a total expenditure of $404,148 in a 12-month period.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 14, 2023
PHYSICIAN AGREEMENT for CLINICAL & ANATOMIC PATHOLOGY SERVICES

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

Physician's Name: Marcus Contardo, M.D. (North Coast Pathology Medical Group, "NCPMG")

Area of Service: Clinical & Anatomic Pathology Services

Term of Agreement: 52 days, Beginning, November 9, 2023 – Ending, December 31, 2023

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

Monthly Cost	Daily Rate	Total
November 9, 2023 – November 30, 2023	$3,000.00	$63,000.00
December 1, 2023 – December 31, 2023	$3,000.00	$93,000.00
Total		**$156,000.00**

Position Responsibilities:

- In order to continue services provided by NCPMG, TCMC will advance a shortfall in collections payment to NCPMG
- NCPMG will exclusively provide all anatomic pathology and clinical pathology (laboratory medicine) professional services in the Department.
- NCPMG will provide an exclusive full-time pathologist Laboratory Director for the Clinical Laboratory and Department of Pathology.
- NCPMG will ensure that there are sufficient physicians available as needed and/or on-call for the Department seven days per week, 24 hours per day.
- NCPMG will provide oversight of all professional services in the Department.
- Assist TCHD in developing, implementing and evaluating a utilization review program, a quality assurance program and a risk management program for the Department.
- Assist TCHD in establishing and evaluating policies, procedures, and protocols for patient care in Pathology and Lab.
- Assist TCHD in meeting accreditation and licensing requirements of the College of American Pathologists, the Joint Commission, the FDA and the CA DHS.
- Assist TCHD in negotiating contracts with providers of outside materials and reference services to the Clinical Laboratory.

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: Eva England, Sr. Director-Ancillary Services / Dr. Gene Ma, Chief Executive Officer

Motion:

I move that the TCHC Board of Directors approve the advanced payment to Marcus Contardo, M.D. as North Coast Pathology Medical Group (NCPMG) for Clinical & Anatomic Pathology Laboratory services for a term of 52 days, beginning November 9, 2023 and ending December 31, 2023, for a total term cost of $156,000.00.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
December 13th, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Cardiac Cath Lab Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
2. Chemotherapy Extravasation Procedure	3 year review, practice change	Forward to BOD for Approval
3. Chemotherapy Patient Intake Procedure	3 year review	Forward to BOD for Approval
4. Controlled Substances Management Policy	3 year review	Forward to BOD for Approval
5. Dialysis, Acute Treatment of the Inpatient Policy	3 year review, practice change	Forward to BOD for Approval
6. Disposal of Chemotherapy Waste Procedure	3 year review, practice change	Forward to BOD for Approval
7. Haloperidol IV Administration Standardized Procedure	2 year review	Forward to BOD for Approval
8. Hypoglycemia Management in the Adult Patient Standardized Procedure	2 year review	Forward to BOD for Approval
9. Immediate Use Sterilization, Intraoperative	RETIRE	Forward to BOD for Approval
10. Medical Equipment Brought into the Facility Policy	3 year review	Forward to BOD for Approval
11. Medication Reconciliation Policy	3 year review, practice change	Forward to BOD for Approval
12. Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Standardized Procedure	2 year review	Forward to BOD for Approval
13. Organ Donation, Including Tissue and Eyes Policy	3 year review	Forward to BOD for Approval
14. Pain Management Policy	3 year review, practice change	Forward to BOD for Approval
15. Patient Safety Plan	1 year review, practice change	Forward to BOD for Approval
16. Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
17. Profend Standardized Procedure	NEW	Forward to BOD for Approval
18. RN Managed Urinary Catheter Removal Standardized Procedure	NEW	Forward to BOD for Approval
19. Transport/Transfer of Patients Within the Facility Policy	3 year review, practice change	Forward to BOD for Approval
Cardiac Rehab		
1. Contraindication to Cardiac Rehab Exercise	3 year review, practice change	Forward to BOD for Approval
2. Exercise Prescription	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 13th, 2023

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
3. Exercise Protocol, Phase II	3 year review, practice change	Forward to BOD for Approval
4. Patient Enrollment	3 year review, practice change	Forward to BOD for Approval
Environment of Care		
1. Fire Plan (Code Red) 3005	1 year review, practice change	Forward to BOD for Approval
2. Life Safety Management Plan	1 year review	Forward to BOD for Approval
Infection Control		
1. Ebola Plan Policy	3 year review	Forward to BOD for Approval
2. Prion Diseases: Transmissible Spongiform Encephalopathies IC 6-5	3 year review	Forward to BOD for Approval
Medical Staff		
1. Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds 8710-522	Practice change	Forward to BOD for Approval
2. Criteria Pain Management Privileges 8710-541	3 year review	Forward to BOD for Approval
3. Physician/Podiatrist Surgical Assistant 8710-536	3 year review	Forward to BOD for Approval
4. Requests for New Privileges Technology New to TCHD 8710-526	3 year review	Forward to BOD for Approval
Pharmacy		
1. Pharmacy and Therapeutics Committee	Practice change	Forward to BOD for Approval
Surgical Services		
1. Duodenoscope Sampling for Quality Control Culturing Procedure	3 year review	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARDIAC CATH LAB PROCEDURES

I. **POLICY:**
- A. Function: Provide care for patients who will be receiving services through the Cardiac Cath Lab.
- B. Circumstances:
  1. Setting: Tri-City Medical Center (TCMC) Cath Lab
  2. Supervision: None required.
  3. Patient contraindications: None.
- C. Expected Outcomes:
  1. To outline personnel and duties involved in procedures in the Cath Lab.
  2. To delineate steps in elective or emergent procedure in the Cath Lab.
  3. To assure that any patient undergoing a cardiac procedure at TCMC will be assessed for pre-procedure risk and will be directed to the appropriate level of care.

II. **PROCEDURE:**
- A. Cardiac Catherization with Possible Percutaneous Transluminal Coronary Intervention
  1. The Registered Nurse (RN) shall order the following if previous results are greater than 90 days or no results are available:
     - a. Obtain previous lab and history and physical, if available.
     - b. Cardiology:
       - i. Electrocardiogram (EKG). Retrieve and print any previous EKG, if available.
     - c. Labs:
       - i. Complete blood count (CBC)
       - ii. Complete Metabolic Panel (Chem 12)
       - iii. PT/PTT/INR
       - iv. Lipid Panel
       - v. Labs may be drawn prior to procedure.
     - d. Nurses Order:
       - i. Start 22, 20 or 18 gauge Intravenous (IV)
       - ii. IV Normal Saline (NS) at 20 mL/hour
       - iii. Point of care (POC) blood glucose, if patient diabetic.
     - e. Diet:
       - i. Ensure nothing by mouth (NPO) prior to procedure except for small amounts of water to take oral medications.
- B. Elective Cardioversion:
  1. The RN shall order the following, if previous results from greater than 90 days or no results available:
     - a. Obtain previous lab & history and physical, if available.
     - b. Cardiology:
       - i. EKG. Retrieve and print any previous EKG, if available.
     - c. Labs:
       - i. INR, complete metabolic panel (Chem 12), CBC
       - ii. Labs may be drawn prior to procedure.
     - d. Nurses Order:

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

i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hour
iii. POC blood glucose, if patient diabetic.

e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

C. Pericardiocentesis:

1. The RN shall order the following, if previous results from greater than 90 days or no results available:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete Metabolic Panel (Chem 12)
iii. PT/PTT/INR
iv. Labs may be drawn prior to procedure.
d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hour
iii. POC blood glucose, if patient diabetic.
e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

D. Implantable Cardioverter Defibrillator Implant/Change:

1. The RN shall order the following, if needed:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. INR/ PT/ PTT
iv. BNP
v. Labs may be drawn prior to procedure.
d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. NS at 20 mL/hour
e. Diet:
i. Ensure NPO after midnight, except for small amounts of water to take oral medications.

E. Permanent Pacemaker Insertion/Change:

1. The RN shall order the following, if previous results from greater than 90 days or no results available:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. PT/PTT/INR
iv. Labs may be drawn prior to procedure
d. Nurses Order:
i. Start 22, 20 or 18 gauge IV

ii. IV NS at 20 mL/hour
iii. POC blood glucose, if patient diabetic.

e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

F. Implantable Loop Device Implant/Explant:

1. The RN shall order the following, if previous results from greater than 90 days or no results available:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. INR
iv. Labs may be drawn prior to procedure.
d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hour
iii. POC blood glucose, if patient diabetic.
e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

G. Transcatheter aortic valve replacement (TAVR)

1. The RN shall order the following, if previous results from greater than 90 days or no results available:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. INR
iv. Labs may be drawn prior to procedure.
d. Nurses Order:
i. Start 22, 20 or 18 gauge IV
ii. IV NS at 20 mL/hour
iii. POC blood glucose, if patient diabetic.
e. Diet:
i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.

H. Left Atrial Appendage Closure (LAAO)

1. The RN shall order the following, if previous results from greater than 90 days or no results available:
a. Obtain previous lab and history and physical, if available.
b. Cardiology:
i. EKG. Retrieve and print any previous EKG, if available.
c. Labs:
i. CBC
ii. Complete metabolic panel (Chem 12)
iii. INR
iv. Labs may be drawn prior to procedure.

d. Nurses Order:
- **i. Start 22, 20 or 18 gauge IV**
- **ii. IV NS at 20 mL/hour**
- **iii. POC blood glucose, if patient diabetic.**

e. Diet:
- **i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.**

I. Patent Forman Ovale (PFO) Closure

1. The RN shall order the following, if previous results from greater than 90 days or no results available:

a. Obtain previous lab and history and physical, if available.

b. Cardiology:
- **i. EKG. Retrieve and print any previous EKG, if available.**

c. Labs:
- **i. CBC**
- **ii. Complete metabolic panel (Chem 12)**
- **iii. INR**
- **iv. Labs may be drawn prior to procedure.**

d. Nurses Order:
- **i. Start 22, 20 or 18 gauge IV**
- **ii. IV NS at 20 mL/hour**
- **iii. POC blood glucose, if patient diabetic.**

e. Diet:
- **i. Ensure NPO prior to procedure, except for small amounts of water to take oral medications.**

~~i.~~

III. **REQUIREMENTS FOR REGISTERED NURSE INITIATING STANDARDIZED PROCEDURE:**

A. Current unencumbered California RN license.
B. Current Advanced Cardiac Life Support (ACLS) certification.
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annually

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

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

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

A. All Registered Nurses who have successfully completed orientation are authorized to direct and perform the Cath Lab Standardized Procedure.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CHEMOTHERAPY EXTRAVASATION**
Purpose:	To outline the responsibility of the registered nurses in the event of chemotherapy extravasation
Supportive Data:	The Oncology Nursing Society Chemotherapy Biotherapy and Guidelines sets the standard for best practice in the care of oncology patients.
Equipment:	Extravasation Kit

A. **DEFINITIONS:**

1. Extravasation: Passage or escape into tissue of antineoplastic drugs. Tissue slough and necrosis may occur.
   a. Extravasation is a medical emergency. Immediate intervention must occur if extravasation is suspected.
2. Flare Reaction: A local allergic reaction to an agent, manifested by streaking or red blotches along the vein, but without pain.

B. **POSSIBLE SIGNS AND SYMPTOMS OF EXTRAVASATION:**

1. Swelling (most common)
2. Stinging, burning, or pain at the injection site (not always present)
3. Intravenous (IV) flow rates that slow or stop
4. Lack of blood return (extravasation can occur with the presence of a blood return)
5. Erythema, inflammation, or blanching at the injection site (not always immediately evident)
6. Induration
7. Vesicle formation
8. Ulceration
9. Necrosis -- Tissue damage may progress for six months after the incident
10. Sloughing
11. Damage to tendons, nerves and joints

C. **CHEMOTHERAPEUTIC VESICANTS AND IRRITANTS THAT CAN CAUSE TISSUE DAMAGE**

1. **Vesicants**
   - **a. Cabazitaxel**
   - **b. Dactinomycin**
   - **c. DAUNOrubicin**
   - **d. Daunorubicin and cytarabine lipsome**
   - **e. Docetaxel**
   - **f. DOXOrubicin**
   - **g. Epirubicin**
   - **h. Idarubicin**
   - **i. Lurbinectedin**
   - **j. Mitomycin C**
   - **k. Mitoxantrone**
   - **l. PACLItaxel (irritant with vesicant-like properties)**
   - **m. PACLitaxel protein bound**
   - **n. Trabectedin**
   - **o. VinBLAStine**
   - **p. VinCRIStine**
   - **q. VinCRIStine liposome encapsulated**
   - **r. Vinorelbine tartrate**

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
02/07; 02/10; 01/13, 05/16, 10/19, **07/23**	03/07; 02/10;2/13, 6/16, 10/19, **08/23**	04/07; 02/10; 02/13; 07/16, 10/19, **08/23**	07/16, 03/20, **10/23**	06/16, 11/19, **09/23**	**04/07;**, 03/10;05/13, 08/16, 04/20, **10/23**	05/20, **12/23**	4/07; 4/10, 6/13, 09/16, n/a	4/07; 4/10, 06/13, 09/16, 05/20

~~a. Alkylating Agents~~
~~i. Mechlorethamine Hydrochloride~~
~~Antitumor Antibiotic~~**~~Mitoxantrone~~**
~~b.~~
~~i. DOXOrubicin~~
~~ii. DAUNOrubicin~~
~~iii. Mitomycin~~
~~iv. Dactinomycin~~
~~v. Epirubicin~~
~~vi. Idarubicin~~
~~c. Vinca Alkaloid or Micro-tubular Inhibiting Agent~~
~~i. vinCRIStine~~
~~ii. vinBLAStine~~
~~iii. Vindesine (non-formulary)~~
~~iv. Vinorelbine~~
~~d. Topoisomerage II Inhibitor~~
~~i. Mitoxantrone~~
~~e. Miscellaneous~~
~~i. Amsacrine~~
~~f. Taxane~~
~~i. PACLItaxel (irritant with vesicant-like properties)~~

2. **Irritants**

~~a. Alkylating Agents~~
a. Ado-trastuzumab emtansine
b. Bendamustine
Bleomycin
c.
d. CARBOplatin
~~i.~~**e. Carmustine**
~~ii.~~**f.** ClSplatin (vesicant at concentrations ≥0.5 mg/ml)
g. Dacarbazine
h. Enfortumab vedotin
i. Etoposide
j. 5-Fluorouracil
~~iii.~~**k. Gemcitabine**
l. Ifosfamide
m. Irinotecan
~~iv.~~**n. Loncastuximab tesirine-lpyl**
~~v.~~**o.** Melphalan
~~vi.~~**p.** OXALIplatin
~~b. Nitrosourea~~
~~i. Carmustine~~
q. Streptozocin
~~ii.~~**r. Topotecan**
~~c. Antitumor Antibiotic~~
~~i. DAUNOrubicin liposomal~~
~~ii.a. Bleomycin~~
~~d. Epipodophyllotoxin~~
~~i. Etoposide~~
~~ii. Teniposide (non-formulary)~~
~~e. Taxane~~
~~i. Docetaxel~~
~~f. Proteasome Inhibitor~~

~~i. Bortezomib~~
~~g. Antimetabolite~~
~~i. Gemcitabine~~

D. **PROCEDURE:**

1. Initial management
   a. Stop administration and IV fluids immediately.
   b. Don two (2) pairs of chemotherapy gloves.
   c. Disconnect the IV tubing from the IV device (central or peripheral IV site). DO NOT REMOVE the peripheral IV or noncoring port needle.
   d. Attempt to aspirate the residual drug from the IV device or port needle by using a 1-3 ml syringe.
   e. Remove the peripheral IV device or port needle
   f. Assess the site of the suspected extravasation and photograph site.
   g. Assess symptoms experienced by patient.
   h. Notify the physician and report the patient's symptoms, amount of extravasation and the extent of the extravasation~~. Review Vesicant Extravasation Management Guidelines with physician~~ and obtain orders for treatment.
      i. For central lines, collaborate with physician regarding the need to discontinue the central line, need for a radiographic flow study to determine the cause of the extravasation and future plans for IV access.
   i. Administer antidote if ordered by physician per the manufacturer's recommendations.
   j. Apply ~~a hot or~~**heat or** cold ~~compress~~ **pack** ~~per Vesicant Extravasation Management Guidelines~~**depending on the medication.**
      i. Cold pack- for all extravasations EXCEPT the vinca alkyloids, etoposide and oxaliplatin, apply a cold pack for 15-20 minutes minimum four times per day for 24-48 hours.
      ~~j.~~**ii. Hot pack. For vinca alkyloids, etoposide and oxaliplatin, apply a heat pack for 15-20 minutes minimum four times per day for 24-48 hours.**
   k. Document the following information in the medical record:
      i. Description of the events that occurred
      ii. Drug
      iii. Dilution
      iv. Amount of Drug Infiltrated
      v. Method of Drug Administration
      vi. Type of IV device
      vii. Description of Site
         1) Size
         2) Color
         3) Texture
   l. Document Physician Notification
2. Post–Extravasation Care
   a. Photograph the initial extravasation site including:
      i. Measuring guide for size or length / width / depth
      ii. Date of photograph
      iii. Patients initials
      iv. Medical record number
      v. Location
   b. Photograph every Monday, Wednesday and Friday.
   c. Instruct the patient to rest and elevate the site for 48 hours and then may resume normal activity.

d. Give patient written instructions regarding what symptoms they should report immediately, local care of the site, pain management and the plan for follow up. Document all patient education in the Cerner Education All Topics Powerform.
e. Educate patient to ensure that no medications are given distally to an extravasation injury.

E. **RELATED DOCUMENTS:**

1. PCS Procedure: Chemotherapy Administration
2. ~~Vesicant Extravasation Management Guidelines~~

F. **REFERENCES:**

1. Chu E, DeVita VT, Jr., Copur MS et al. Physicians' Cancer Chemotherapy Drug Manual 2008. Sudbury: Jones and Barlett, 2008
2. Clamon GH. The Chemotherapy Source Book. 4th ed. Philadelphia. Lippincott Williams & Wilkins, 2008: 148-51
3. Goolsby TV and Lombardo FA. Extravasation of Chemotherapeutic Agents: Prevention and Treatment. Seminars in Oncology. 2006; 33(1): 139-43
4. Infusion Nursing Society (January/February 2011). Infusion Nursing Standards of Practice. Journal of Infusion Nursing, Vol. 34, Number 1S.
5. Jackson-Rose, J. et al. (2017). Chemotherapy extravasation: Establishing a national benchmark for incidence among cancer centers. *Clinical Journal of Oncology Nursing, 21(4)*. doi: 10.1188/17.CJON.438-445.
6. The Oncology Nursing Society (202~~319~~). ONS Chemotherapy and Immunotherapy **Guidelines and Recommendations for Practice**, p. **363-368**~~255-257~~.

~~Vesicant Extravasation Management Guidelines~~
~~Oncology Nursing Society (2019) Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice. pp 255-257~~

Table 13-3. Vesicant Extravasation Management Guidelines

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Alkylating agents • Mechlorethamine hydrochloride (nitrogen mustard, Mustargen®)	Apply cold pack for 8–12 hours following sodium thiosulfate antidote injection (Lundbeck LLC, 2012).	Antidote: Sodium thiosulfate Mechanism of action: Neutralizes mechlorethamine to form nontoxic thioesters that are excreted in the urine	Inject 2 ml of the sodium thiosulfate solution for each milligram of mechlorethamine suspected to have extravasated. Inject the solution subcutaneously into the extravasation site using a 25-gauge (change needle with ...ose may be divided ...to inject around the site ...The needle should be ...h new injection. ...ation area for pain, ...and skin sloughing peri- ...d or in accordance with ... ...monitor the extravasa- ...port fever, chills, blister- ...g, and worsening pain. ...h peripheral extravasa- ...n or hand swelling and ...
• Trabectedin (Yondelis®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy (Janssen Pharmaceutical Companies, 2015). In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

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Table 13-3. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Anthracenedione • Mitoxantrone (Novantrone®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Extravasation typically causes blue discoloration of the infusion site area and may require debridement and skin grafting (Fresenius Kabi USA, 2013). Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain services).
Antitumor antibiotics (anthracyclines) • Daunorubicin (Cerubidine®) • Doxorubicin (Adriamycin®) • Epirubicin (Ellence®) • Idarubicin (Idamycin®)			nfusion as 6 hours of ion. hours in than the osite arm). ed only atus (e.g., recludes use large vein should be istration. be applied to
		day 3. The dose should be reduced 50% in patients with creatinine clearance values < 40 ml/min. Preparation: Each 500 mg vial of dexrazoxane must be mixed with 50 ml diluent. The patient's dose is then added to a 1,000 ml normal saline infusion bag for administration. Storage: Store at room temperature between 15°C–30°C (59°F–86°F).	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. Instruct patients to monitor the extravasation site and to report fever, chills, blistering, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness. Instruct patients about treatment side effects (e.g., nausea, vomiting, diarrhea, stomatitis, bone marrow suppression, elevated liver enzyme levels, infusion site burning). Monitor patients' complete blood count and liver enzyme levels.
Antitumor antibiotics (miscellaneous) • Dactinomycin (actinomycin D, Cosmegen®) • Daunorubicin and cytarabine (Vyxeos™) • Doxorubicin hydrochloride liposome (Doxil®) • Mitomycin (Mutamycin®)	Apply cold pack for 15–20 minutes at least 4 times a day for the first 24 hours.	No known antidotes or treatments exist.	Assess the extravasation area for pain, blister formation, and skin sloughing periodically as needed or in accordance with institutional policy. In collaboration with the provider, refer patients for specialized care when indicated or needed (e.g., plastic or hand surgery consult, physical therapy, pain management, rehabilitation services).

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Table 13-3. Vesicant Extravasation Management Guidelines *(Continued)*

Classification/Drug	Immediate Topical Therapy	Antidote or Treatment	Administration, Monitoring, and Follow-Up
Plant alkaloids and microtubule inhibitors • Vinblastine (Velban®) • Vincristine (Oncovin®)	Apply warm pack for 15–20 minutes at least 4 times a day for the first 24–48 hours. Elevate extremity (peripheral extravasations).	Antidote: Hyaluronidase (Kreidieh et al., 2016) Mechanism of action: Degrades hyaluronic acid and promotes drug dispersion and absorption Preparation: Prepare per pack	Administer 150 units of the hyaluronidase solution as 5 separate injections, each containing 0.2 ml of hyaluronidase, subcutaneously into the extravasation site using a 25-gauge or smaller needle (change needle with each injection). Assess the extravasation area for pain, and skin sloughing peri- d or in accordance with y. monitor the extravasa- port fever, chills, blister- g, and worsening pain. th peripheral extravasa- m or hand swelling and
Taxanes • Cabazitaxel (Jevtana®) • Docetaxel (Taxotere®) • Paclitaxel (Taxol®) • Paclitaxel protein-bound particles for injectable suspension (Abraxane®)			sation area for pain, and skin sloughing peri- d or in accordance with y. monitor the extravasa- port fever, chills, blister- ing, skin sloughing, and worsening pain. Instruct patients with peripheral extravasations to report arm or hand swelling and stiffness.

DELETE Grid

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CHEMOTHERAPY PATIENT INTAKE**
Purpose:	To outline the responsibility of the physicians' offices and the Tri City Healthcare District departments taking direct admissions, outpatients and justice involved patients for chemotherapy administration and monitoring.

A. **PROCEDURE:**

1. The physician's office/correctional facility will notify the appropriate department of the direct admits or outpatient chemotherapy that will receive care from Tri City Medical Healthcare District.
2. The department will complete the intake per department process when notified of a pending direct admit or outpatient chemotherapy.
3. The department will contact registration to ensure the patient is registered prior to treatment.
4. The department providing care will scan the chemotherapy orders to pharmacy and make a follow-up call to pharmacy to verify that the orders were received.
   a. All direct admissions, outpatient or justice involved chemotherapy orders must be scanned prior to 1300 if chemotherapy is to begin the same day the intake information is obtained so pharmacy has ample time to order and prepare the chemotherapy.
5. The department providing care will ensure there is proper coverage of chemotherapy competent nurses for the pending chemotherapy patient. The schedule will be reviewed by Nursing Leadership/designee every shift to evaluate that there will be chemotherapy nurse coverage for the pending chemotherapy patient 24 hours prior to the patient arriving.
6. The department providing care will contact pharmacy prior to the on coming shift that is expecting the chemotherapy patient to ensure that the chemotherapy has been ordered and is ready for preparation before patient arrives on the unit for that day. They will also assign a chemotherapy nurse to that patient prior to the shift that the patient is to arrive for treatment.
7. When patient arrives on the unit for their chemotherapy the primary care nurse should verify that the patient has completed the registration process prior to receiving any treatment.
   a. Contact registration at extension 3151 when forensic outpatient chemotherapy patients arrive on the unit.
8. The primary nurse will contact pharmacy to coordinate time of chemotherapy preparation at the beginning of the shift or as soon as the patient arrives to the unit.
9. The primary nurse/Charge Nurse will forward any charges for chemotherapy to the appropriate department (including but not limited to outpatient chemotherapy and any other IV's or medications that were administered during the chemotherapy treatment).

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

1. Chemotherapy Information Intake Form

Department Review	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/12, 12/19, 03/20, **07/23**	09/12, 06/20, **07/23**	09/12, 07/20, **08/23**	n/a	09/20, **09/23**	10/12, 11/20, **10/23**	12/20, **12/23**	11/12, n/a	12/12, 12/20

Chemotherapy Information Intake Form

This information must to be obtained when the physician or physician's office calls the Oncology Unit to schedule Direct Admits or Outpatient Chemotherapy

□ Direct Admit □ Outpatient ~~□ Forensic~~

Today's date	
Name of person requesting bed (Tell them to have patient check in at registration before they come to the unit on the day of treatment- This does not apply to forensic patients)	
Phone #	
Date bed needed	
Physician requesting bed	
Patient's name/Diagnosis	
Phone # to contact patient (non-forensic)	
Age and DOB of patient	
--Hx of MRSA? C-diff?	
Direct/ Outpatient Chemotherapy Patients (non-forensic) MD office to fax to 2P: 1. Insurance information 2. Chemotherapy Orders 3. Authorization for Chemo/ Admission *Fax these to registration at x4016 1. Put Pt arrival Date on Chemo Calendar 2. Call Bed Coordinator with Pt Arrival Date	Time/Date Faxed-: _____ Call x 3151 to confirm fax was received Name of pharmacy personnel confirming fax p: _____
~~Outpatient Chemotherapy- Forensic Patients~~ ~~Correctional Facility to fax to Forensic Unit:~~ ~~1. Healthcare Services Physician Request for Services Form~~ ~~Physician's Office to Fax:~~ ~~1. Chemotherapy Orders~~ ~~*Fax these to registration at x4016~~	~~Time/Date Faxed-~~ ~~Call x3151 to confirm fax was received~~ ~~Name of pharmacy personnel confirming fax:~~ _____
2P ~~ANM or~~ Charge Nurse to scan this form and orders to Pharmacy, -Verify they received Scan	Time/Date Scanned-: _____ Name of pharmacy personnel verifying : _____
Comments	
~~ANM or n~~Nurse completing intake form	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**08/01, 11/12**	**SUBJECT:**	**Controlled Substances Management**
REVISION DATE:	**01/03, 03/03, 07/05, 04/08, 09/09, 11/12, 03/14, 06/18**		

Patient Care Services Content Expert~~Department~~ Approval:	**~~02/17~~11/21**
Clinical Policies & Procedures Committee Approval:	**~~03/17~~12/21**
Nursing Leadership~~Executive Committee~~ Approval:	**~~03/17~~01/22**
Pharmacy & Therapeutic Committee Approval:	**~~05/17~~02/22**
Department of Anesthesiology Committee Approval:	**~~05/18~~10/23**
Medical Executive Committee Approval:	**~~05/18~~10/23**
Administration Approval:	**12/23**
Professional Affairs Committee Approval:	**~~06/18~~ n/a**
Board of Directors Approval:	**06/18**

A. **DEFINITION(S):**
1. Controlled Substance: as defined by the state and federal law.

B. **POLICY:**
1. Healthcare providers shall administer controlled substances in compliance with their respective Practice Acts, Tri-City Healthcare District (TCHD) Policies and Procedures, and state and federal law.
2. All controlled substances for administration shall be maintained in the Pyxis MedStation.
3. Sequential dosing of controlled substances is not permitted at TCHD except by physicians.
4. Abuses and losses of controlled substances shall be reported to the Director of Pharmacy.

C. **PROCEDURE:**
1. Replenishment:
   a. Pyxis System Controlled Substances:
      i. Pharmacy personnel shall automatically replenish the controlled drugs in each Pyxis Medstation.
      ii. All controlled substances removed from Pyxis for administration shall be documented on the patient electronic or paper Medication Administration Record (MAR). Whenever possible, it is recommended that the nurse removing the controlled substance from the Pyxis is to be the nurse who administers the medication, thus ensuring the chain of custody of the medication.
      iii. PRN response shall be documented on all narcotics.
2. Nursing Units Controlled Substance Accountability:
   a. Pyxis Nursing Units:
      i. The Pyxis home screen must be reviewed before the end of each shift to determine if there is an open discrepancy.
      ii. Any controlled substance discrepancy must be resolved by the end of each shift and resolution noted in the Pyxis.
      iii. Unresolved discrepancies are not acceptable and shall be reported to the ~~Assistant~~ Nursinge Leader~~Manager (ANM)~~/designee immediately.
      iv. A manual weekly inventory of all controlled substances is required.
3. Security/Storage:
   a. Pyxis Nursing Units:

i. All controlled substances are kept in the Pyxis Medstation.

4. Wasting Of Controlled Drugs:
   a. Any opened controlled substance not given or any unused partial doses shall be wasted; wastage shall be witnessed, documented, and co-signed by two licensed personnel based upon their scope of practice.
      i. The following licensed personnel may witness and co-sign wasting of controlled substances:
         1) Anesthesiologist
         2) Registered Nurse
         3) Licensed Vocational Nurse
         4) Respiratory Care Practitioner
         5) Radiology Technologist
         6) Pharmacist
         7) Pharmacy Technician
   b. Witnessing of wastage, documentation of wastage, and cosigning shall occur:
      i. Within one (1) hour after administration or removal of the drug
      ii. For procedural areas: within one (1) hour after completion of procedure
      iii. If medication is removed and not administered.
         1) Returned to Pyxis if intact
         2) Wasted if no longer intact
   c. The licensed personnel administering the medication shall document the amount wasted.
   d. ALL controlled substance waste (solid, liquid and patches) shall be disposed of in the designated RX Destroyer container.
      i. Discard empty syringe into the trash unless a needle attached, then discard in sharps container.
5. Controlled substances auditing procedure:
   a. The Pharmacy Department will perform regular retrospective audits on all hospital personnel who have access to controlled substances via the automatic dispensing machines.
      i. For all nursing units,
         1) Pharmacy personnel shall generate a Proactive Diversion Report monthly to identify user activity that falls out of the normal range compared to their peers.
         2) For users with a standard deviation of +3 or greater, pharmacy personnel shall notify the nursing manager and send a Pyxis Medstation Report and documentation form for review and completion.
         3) Nursing **Leadership**~~management~~ shall conduct an investigation of reported users to verify controlled substances activity as appropriate.
         4) Nursing **Leadership**~~management~~ shall return completed documents to pharmacy personnel within 14 days.
      ii. For Anesthesiology Department,
         1) Pharmacy personnel shall generate a detailed report of all audit activity, at least monthly and submit it to the Anesthesia Department Chair in order that evaluation and remediation may be carried out.
         2) In the event that any single day the retrospective audit reveals a concerning non-compliance event, the individual Provider will be notified so prompt evaluation and remediation can be carried out. If the individual provider can't be contacted directly, the Anesthesia Department Chair will be notified so they can assist in contacting the Provider so prompt evaluation and remediation can be carried out.
6. Reporting of abuses and losses of controlled drugs:

a. An investigation by the management team of the area where loss occurred and the pharmacy will be conducted. Findings along with recommendations for action will be made to appropriate staff.
   i. Abuses and losses of controlled substances involving a medical staff credentialed provider will be reported to the Medical Staff Manager and must be reported, in accordance with applicable Federal and State laws, to the Director of Pharmacy, and to the Chief Nurse Executive or chief executive officer, as appropriate.

D. RELATED DOCUMENT(S):

1. TCMC Waste Disposal Guidelines

TCMC Waste Disposal Guidelines

						 
Regular Waste **NO NEEDLES, NO PHI**	**Biohazardous Waste** **NO NEEDLES**	**Sharps** **NEEDLES OK**	**Pharmaceuticals** **NEEDLES OK, NO PHI,**	**Controlled Substances** **NO NEEDLES, NO PHI**	**RCRA Pharmaceuticals** **NO NEEDLES, NO PHI**	**Chemo/Hazardous Waste** NO PHI, NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags or tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles)	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ **All sharps** Example: needles (**including** needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with **pourable** medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants *Examples: Advair, Foradil*	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, Lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing**	**EPA designated R.C.R.A. Pharmaceuticals only:** Examples: ▫ Insulin/Insulin Pen ▫ Inhalers -only those w/ propellant e.g Ventolin, ▫ Warfarin /Coumadin ▫ Used & Unused nicotine gum or patches, (include empty wrappers) ▫ Silver sulfadiazine cream ▫ Silver nitrate applicators (unused) ▫ Selenium sulfide shampoo ▫ Multiple trace elements ▫ Unused& residual alcohol/acetone/acetic acid **All bulk chemo to be disposed in RCRA container**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous medications

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973).
If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: https://www.sandiegocounty.gov/content/dam/sdc/deh/hmd/presentations/hmd_Management_of_Pharmaceutical_Waste.pdf
http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; **County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle. Healthcare Environmental Resource Center, Epinephrine Fact Sheet** http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017, 08/2022
Administrative Policy: Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions 276

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**3/02**	**SUBJECT:**	**Dialysis, Acute Treatment of the Inpatient**
REVISION DATE:	**10/02, 06/03, 04/06, 07/08, 05/11,~~;~~ 06/14, 08/14, 07/15**		

Patient Care Services Content Expert Approval:	**~~10/19~~05/23**
Clinical Policies & Procedures Committee Approval:	**~~11/19~~07/23**
Nursing Leadership~~Executive Committee~~ Approval:	**~~04/20~~08/23**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~05/20~~09/23**
Medical Executive Committee Approval:	**~~08/20~~10/23**
Administration Approval:	**~~09/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/20**

A. **POLICY:**

1. Tri-City Medical Center (TCMC) has a contractual agreement with San Diego Dialysis (Fresenius) to perform acute hemodialysis and peritoneal dialysis for inpatients.
2. Dialysis will be done in the patient's room.
3. Emergency situations:
   a. The dialysis registered nurse (RN) will implement a Rapid Response or Code Blue if necessary by dialing 66 via the phone to report a Code Blue and initiate Basic Life Support (BLS) to the dialysis patient.
   b. In case of emergent situation, the Nursing Leadership or designee on the unit will be notified immediately by the dialysis nurse.
   c. The Rapid Response Team (RRT) will be contacted to provide care for the dialysis patient if the dialysis nurse becomes incapacitated until a replacement dialysis RN can be found or treatment is discontinued.
4. TCMC's direct care responsibilities for patients undergoing dialysis treatments are as follows:
   a. Delivering nursing care as needed ~~normally provided to patients while not receiving dialysis,~~ unless otherwise contraindicated during dialysis. This includes treating pain and providing immediate emergency response in the event a patient on dialysis treatment suffers a sudden change in condition.
   b. Administering medications:
      i. The primary RN will be responsible for administering all routine ~~intravenous (IV)~~ medications
      ii. Review the electronic medication administration (EMAR) for post dialysis IV medications. Post Dialysis IV medications are to be administered by the primary RN unless patient has no IV access.
         1) If no IV access, the ~~-~~dialysis nurse will administer the post dialysis IV medications
   c. Providing the dialysis staff with equipment and supplies outlined in Dialysis Supplies and Equipment Provided by TCMC.~~-~~
   d. Providing ~~written~~ ~~-~~physician orders for the necessary dialysis services and making these orders available to the dialysis staff at the time services are to be rendered.
   e. Obtaining a signed consent for hemodialysis from the patient or appropriate designee prior to the first treatment.
   f. Providing access for treatment. The physician who inserts a dialysis catheter is responsible for proper placement via chest x-ray that is confirmed by a radiologist.

5. Fresenius ~~Medical~~ direct care responsibilities for patients undergoing dialysis are as follows:
   a. Providing specially trained and competent nursing staff that will perform all patient care functions directly related to the dialysis services ordered.
   b. Adhering to TCMC policies and procedures, and all regulatory requirements
   c. Providing those items in Dialysis Supplies and Equipment Provided by Fresenius.
   d. Maintaining equipment required for dialysis treatments, including set-up, take down, and cleaning.
   e. Obtaining and reviewing physician orders directly related to the dialysis services for appropriateness, and directly contacting ordering physicians for any order clarification required.
      i. Review for post dialysis medications and request all of the medications from pharmacy.
   f. Administering medication and blood products that are ordered during dialysis.
      i. Medications shall be scanned per Patient Care Services Policy: Medication Administration
      ~~f.~~ii. Blood products will be documented per Patient Care Services Procedure: Blood Products Administration.
   g. Contacting the physician and the primary nurse for any urgent or emergent changes in the patient condition.
   h. Documenting nursing services provided during treatment per Fresenius policy.
      i. The following shall be documented in the electronic health record:
         1) How the patient tolerated the treatment
         ~~1~~)2) Intake/Output
         ~~2~~)3) Vital signs
         ~~3~~)4) Medications and blood products administered during dialysis and post dialysis if no intravenous access
         ~~4~~)5) Central line dressing change (if performed by dialysis RN)
         6) Appropriate dialysis service charges
         ~~5~~)7) Adverse outcomes and associated treatments
   i. Assures patient is medically stable before leaving at completion of treatment.
   j. Participates in a hand-off report with the patient's primary nurse pre and post dialysis treatment.

B. **HANDOFF COMMUNICATION**

1. Before the dialysis treatment starts, the primary RN will provide -a handoff report to the dialysis RN that will include but not limited to:
   a. Vital signs
   b. Weight
   c. Intake/output
   d. Most recent blood sugar as applicable
   e. Review of medication orders, including medications given
   f. Orientation, level of consciousness
   g. Dialysis access
   h. Code status
2. When the patient has completed the dialysis treatment, the dialysis RN will provide hand off report to the primary RN that will include but not limited to:
   a. How patient tolerated treatment
   b. Intake/output including dialysis output
   c. Vital signs
   d. Medications given during dialysis
   e. Blood products administered
   f. Post dialysis access care (i.e. bleeding) and status of dressing
   g. Review of post dialysis medication orders.

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

1. Dialysis Supplies and Equipment Provided by TCMC and Fresenius

Tri-City Medical Center
Oceanside, California

Dialysis Supplies and Equipment

The following exhibit set forth such equipment and supplies to be provided by Hospital (Tri-City Medical Center) pursuant to the contract:

1. Electrodes and monitoring equipment
2. Non-invasive blood pressure monitoring machine
3. IV infusion pumps and tubing
4. IV administration sets
5. Normal Saline
6. Anticoagulant Citrate Dextrose – Formula A Solutions
7. Priming and Replacement fluids
8. Hemoperfusion Cartridge
9. Syringes as needed
10. Hypodermic Needles as needed
11. Iodine swab sticks and Alcohol swabs
12. Tape as needed
13. 2X2 and 4X4 gauze pads (sterile & non) as needed
14. Non sterile gloves, various sizes and latex non-powder same sizes
15. Sterile gloves, various sizes
16. Surgical masks or N 95 masks as needed
17. Blood administration sets and appropriate blood filters
18. Pressure wrap bandage
19. Bed pans and urinals
20. Drinking cups and straws
21. Any other supplies not provided by provider, which are necessary to perform the service.

In instances where any of the foregoing are unavailable, the Hospital shall provide reasonable substitute products.

The following exhibit sets forth such equipment and supplies to be provided by Provider (Fresenius) pursuant to the contract:

Dialysis Supplies

1. Artificial Kidneys
2. Arterial and Venous Blood Lines
3. Transducers
4. Dialyzing Fluids
5. Fistula Needles
6. Universal Connectors
7. Extension Clamps
8. Adapter Seal Clamps
9. Convertible Adapters
10. Drain Set
11. Del Clamps
12. Treatment Record

Apheresis Supplies (general)

1. Blood Cell Separator
2. Blood Cell Separator Tubing set
3. Machine Maintenance
4. Blood Warmer and Blood Warmer Tubing
5. AV Fistula needles

Dialysis Supplies and Equipment

6. Treatment Record

Immunoadsorption Therapy Supplies (in addition to the above apheresis supplies):

1. Plasma transfer sets with spike and needle adapter (Fenwal or equivalent)
2. Transfer pack container 2000 mL with coupler (Fenwal or equivalent)
3. Transfer pack unit 600 mL with needle adapter (Fenwal or equivalent)
4. Y-type blood component recipient set (Fenwal or equivalent)
5. Spike to Syringe Adapter
6. PXL8 Leukocyte filters (Pall or equivalent)
7. Extension Set 3.0 mL 51 cm
8. Needle Lock Device (Baxter or equivalent)
9. Male to male adapter
10. 3-way stopcock

Provider and Hospital agree as new state-of-the-art supplies or equivalent equipment may be substituted as may be worked between both parties.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**DISPOSAL OF CHEMOTHERAPY WASTE**
Purpose:	To outline the nursing responsibility and management of proper disposal of chemotherapy waste
Supportive Data:	Oncology Nursing Society's Chemotherapy and Biotherapy Guidelines and Recommendations for Practice 4th Edition 2014
Equipment:	Chemotherapy Safe Personal Protective equipment Puncture –proof container labeled "chemotherapy" container **or RCRA container** Gloves specified for use with chemotherapy agents Large yellow bag marked "Chemotherapy waste" Gown specified for use with Chemotherapy Agents

A. **PROCEDURE:**

1. Place puncture-proof **trace or bulk** chemotherapy container and large yellow chemotherapy waste plastic bags marked "Chemotherapy Waste" in patient's room upon initiating chemotherapy treatment.
   - **a. If a chemo drug waste contains more than 3% of the residual drug, it is referred to as "bulk chemo waste" and must be disposed in a black Resource Conservation and Recovery Act (RCRA) container.**
   - ~~1.~~**b. If a chemo drug waste contains 3% or less of the residual drug, it is referred to as "trace chemo waste" and can be disposed in a yellow chemotherapy waste container.**
2. Always use chemotherapy safe personal protective equipment when handling chemotherapy waste.
3. Place any disposable cytoxic contaminated materials into a yellow chemotherapy waste plastic bag. Use puncture proof chemotherapy waste containers for sharps, breakable items, and items that are saturated with chemotherapy or chemotherapy contaminated body fluids.
4. Place contaminated Intravenous (IV) tubing, IV bags, and all non-sharp materials in the large yellow plastic bag marked "Chemotherapy Waste" after striking out any patient information on the label or tubing with a black permanent marker.
5. Tie off large yellow chemotherapy waste bag carefully gathering top portion of bag with one hand and slowly pull downward on gathered portion until internal air in bag resists further pulling down. Place yellow chemotherapy waste bag in puncture proof container labeled "Chemotherapy Waste."
6. Place puncture-proof **trace or bulk** chemotherapy container in the chemo waste room when no longer in use or container is 2/3 full.
   - a. For inpatient areas without a chemo waste room, contact Environmental Services (EVS) for removal.
7. Completely close the lid on the chemotherapy puncture proof waste containers when they are 2/3 full or if a potential risk is perceived. Document on top of the puncture proof container "full" with the date before placing it in the chemo waste room or contacting EVS for removal.
8. Notify environmental services when chemotherapy puncture-proof waste containers are full. Chemotherapy containers must be removed from the chemo waste room within 24 hours.
   - **a.** Outpatient Infusion Center staff shall notify currently contracted waste management provider to pick-up chemotherapy waste containers.

B. **REFERENCES:**

~~a.~~**1. American Society of Health-System Pharmacists. ASHP guidelines on handling hazardous drugs. Am J Health-Syst Pharm. 2018; 75:1996- 2031, https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx - accessed 05.03.2023**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/03; 11/11, 05/16, **05/23**	12/11, 08/15, 6/16, **05/23**	09/15, 7/16, **06/23**	07/16, 03/17, 03/19, **10/23**	6/16, **07/23**	1/12, 10/15, 05/19, **10/23**	06/19, **12/23**	2/12, 11/15, n/a	2/12, 12/15, 06/19

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: HALOPERIDOL (HALDOL), INTRAVENOUS (IV) ADMINISTRATION

I. POLICY:

A. Function: To provide direction for the use of intravenously administered Haloperidol at Tri-City Medical Center (TCMC).

B. Circumstances:
   1. Setting: Emergency Department (ED), Intensive Care Unit (ICU), Progressive Care Unit (PCU), Cardiac Cath Lab or Telemetry at TCMC.
   2. Supervision: None.

C. Definitions:
   1. The safe intravenous (IV) administration of haloperidol requires that the QTc interval on the 12 Lead electrocardiogram (ECG) be less than 450 milliseconds.
   2. The safe IV administration of haloperidol requires that the patient be monitored continuously for cardiac dysrhythmias for two (2) hours after the drug is given.
   3. The maximum drug amount for each IV dose of haloperidol is 5mg.
   4. The maximum cumulative drug amount for IV haloperidol dosing is 20mg per 24 hours.
   5. QT interval represents the duration of ventricular depolarization and subsequent repolarization measured from the beginning of the QRS complex to the end of the T wave using manual or electronic calipers.
   6. QTc interval is a heart rate adjustment measurement for the QT interval. It is measured using a calculation and is not the same measurement as the QT interval.
      i. Nursing shall use the QTc interval listed on a 12 Lead ECG.

D. Exceptions:
   1. Haloperidol IV may be given in emergent situations to patients without a 12-lead ECG if the ordering physician determines the benefit ~~to~~ outweighs the risk of treatment.

II. PROCEDURE:

A. The attending physician initiates the process by ordering IV haloperidol for the patient.

B. The Registered Nurse (RN) shall check the chart for the most recent 12 Lead ECG.
   1. RN shall order a baseline 12 Lead ECG if:
      i. There is not an ECG that was done within the past 24 hours available on the chart.
      ii. Patient is at risk for prolonged QT intervals:
         a) Atrioventricular (AV) blocks
         b) History of Torsades de Pointes (TdP)
         c) Long QT Syndrome
         d) History of Myocardial Infarction (MI)
      iii. When recommended by pharmacy based on drug interaction that prolongs the QT interval.
      iv. When the QT interval on an ECG strip measured with calipers~~,~~ prolongs, exceeding the patient's baseline and/or exceeds 450 milliseconds.
   2. Patients receiving 20mg or more of haloperidol IV per day~~, order~~ the RN shall order a 12 lead ECG every other day, if not ordered by the physician, to monitor the QTc.

C. The RN or physician shall check the QTc interval that is electronically measured and printed on the 12 Lead ECG.

Patient Care Services Content Expert	Clinical Policies & Procedures ~~Committee~~	Nursing Leadership ~~Executive Committee~~	Division of Cardiology	Pharmacy & Therapeutics Committee	Inter-disciplinary Practice Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
07/12, 09/15, 03/19, **09/22**	08/12, 10/15, 04/19, **10/22**	10/12, 10/15, 04/19, **11/22**	01/16, 06/19	11/12, 01/16, 07/19, **01/23**	02/13, 07/16, 10/19, **07/23**	02/13, 09/16, 11/19, **10/23**	11/19, **12/23**	10/16, n/a	02/13, 11/16, 12/19

1. Do not administer haloperidol if the QTc interval is greater than 450 milliseconds. Discontinue the haloperidol and notify the physician for an alternative route or medication.
2. If the physician specifically orders haloperidol despite QTc greater than 450 milliseconds, document QTc and physician notification of QTc.

D. The RN shall document the QTc interval on the medication administration record (MAR).

E. The patient shall be monitored for the following for 2 hours after haloperidol has been administered:
1. Cardiac effects (new onset tachycardia, orthostatic hypotension, hypertension, abnormal T waves, prolongation of the QT from baseline and ventricular dysrhythmias).
2. Signs of neuroleptic malignant syndrome (new fever greater than 37.7 celsius, tachycardia, diaphoresis, labile blood pressure, cardiac dysrhythmias).
3. Extrapyramidal reactions, including:
   i. Dystonic reactions (neck rigidity, swollen tongue, and oculogyric crisis).
   ii. Tardive dyskinesia (repetitive, involuntary, purposeless movements, grimacing, tongue protrusion, lip smacking, puckering and pursing, rapid eye blinking, rapid movements of the arms, legs, and trunk may also occur. Involuntary movements of the fingers may appear as though the patient is playing an invisible guitar or piano).

F. Physician Notification and Documentation
1. Notify the physician and document in the medical record the presence of the following:
   i. Cardiac effects
   ii. Signs of neuroleptic malignant syndrome
   iii. Extrapyramidal reactions
2. When administering medications or implementing orders from a standardized procedure, the RN shall enter the medication/order into the electronic health record as a standardized procedure.
   i. Not required if a screening process triggers the order.

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current unencumbered California RN license.
B. Current Advanced Cardiac Life Support certification.
C. Primary RN staff on unit with continuous cardiac monitoring at TCMC.
D. Initial Evaluation: During Department Orientation.
E. Ongoing Evaluation: Annually with skills validation.

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Haloperidol, Intravenous (IV) Administration Standardized Procedure.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: HYPOGLYCEMIA MANAGEMENT IN THE ADULT PATIENT

I. **POLICY:**
- A. Function: Management of the adult patient with hypoglycemia.
- B. Circumstances:
  1. Setting: Tri-City Healthcare District using hospital approved point of care blood glucose meter
- C. Excludes: Patients on intravenous insulin infusion.

II. **ASSESSMENT:**
- A. Assess patient for hypoglycemia:
  1. Blood glucose less than 70 mg/dL with or without symptoms.
  2. Early adrenergic symptoms may include pallor, diaphoresis, tachycardia, shakiness, hunger, anxiety, irritability, headache, dizziness
  3. Later neuroglycopenic symptoms may include confusion, slurred speech, irrational or uncontrollable behavior, extreme fatigue, disorientation, loss of consciousness, seizures, pupillary sluggishness, decreased response to noxious stimuli.

III. **TREATMENT:**
- A. Treat if the point of care (POC) blood glucose is:
  1. Less than 70 mg/dL for the diabetic patient, non-diabetic patient and outpatient
  2. Less than 60 mg/dL for the pregnant patient during all phases of the pregnancy
- B. If patient is conscious and able to tolerate oral intake, give one 15 gram tube of glucose gel. May give 4 ounces orange or apple juice if patient refuses glucose gel.
  1. If the POC blood glucose was less than 50 mg/dL give an additional 15 gram tube of glucose gel (total of 30 grams of glucose gel). May give additional 4 ounces orange or apple juice if patient refuses glucose gel (total of 8 ounces orange or apple juice).
- C. If patient is NPO or unable to tolerate oral intake or has a decreased level of consciousness, administer:
  1. 30 mL of 50% Dextrose intravenously (IV) at a rate of 10mL per minute.
     a. If the POC blood glucose was less than 50 mg/dL give an additional 20 mL of 50% dextrose (total of 50 mL of 50% dextrose)
  2. If no IV access, Glucagon 1 mg subcutaneously (SQ) or intramuscularly (IM) times one (do not repeat).
- D. Recheck POC blood glucose in 15-30 minutes after treatment.
  1. If equal to or greater than 70 mg/dL, no additional treatment required.
  2. If still less than 70 mg/dL:
     a. Repeat above treatment
     b. Obtain serum blood glucose to verify blood glucose level
     c. If repeated POC blood glucose and initial POC blood glucose was less than 50 mg/dL notify physician and request a 10% dextrose infusion
- E. Notify the attending physician/AHP immediately only if treatment is ineffective, otherwise notify physician of hypoglycemic episode(s) prior to next dose of scheduled insulin or hypoglycemic agent.
- F. Treatment of serum (lab draw) blood glucose if less than 70mg/dL:
  1. Because serum blood glucose is resulted at least 40 minutes (or more) after the blood is

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Diabetic Task Force	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
08/12, 10/18	09/12, 4/15, 01/17, 11/18, **07/23**	09/12, 4/15, 02/17, 11/18, **08/23**	05/15,12/16, 02/17, 12/18	11/12, 05/15, 03/17, 01/19, **09/23**	01/13, 09/15, 04/17, 04/19, **10/23**	02/13, 09/15, 04/17, 05/19, **10/23**	06/19, **12/23**	10/15, 05/17, n/a	02/13, 10/15, 05/17, 06/19

drawn, recheck with POC blood glucose prior to treatment. If less than 70 mg/dL, treat as outlined above.

I. DOCUMENTATION:

A. Document the following:
   1. Document patient symptoms, glucose values, treatments, and patient's response to treatment and physician notification in the medical record.
   2. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.
      a. Not required if a screening process triggers the order.
   3. Document administration of medications on the Medication Administration Record

II. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current unencumbered California RN license.
B. Education and Training: Blood glucose analysis training using blood glucose monitoring device including hypoglycemia management.
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual blood glucose monitoring device review with return demonstration and hypoglycemia management.

III. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

IV. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform Hypoglycemia Management Standardized Procedure.

V. REFERENCE(S):

A. California Diabetes and Pregnancy Program Sweet Success: Guidelines for Care. 2015. California Department of Public Health.
B. Clinical Diabetes, Volume 34, Number 4, Fall 2016, American Diabetes Association.
C. Diabetes Spectrum Volume 18, Number 1, 2005.
D. Hospital Practice, 2016, Volume 44, No. 1, 1-8.
E. Rule of 15 endorsed by the ADA and Mayo Clinic, Complete Nurses Guide to Diabetes Care, second edition, ADA, 2009.

Tri-City Medical Center | Patient Care Services

PROCEDURE: IMMEDIATE USE STERILIZATION, INTRA

RETIRE – no longer perform Immediate Use Sterilization, refer to Sterile Processing Procedure: Operation and Cleaning

Purpose: To provide guidelines for rapid sterilization
for immediate use in an operative procedur
process is dependent upon effective cleani
Substances such as bioburden, biofilm, plaques, soils, and oils inhibit sterilization. The degree to which sterilization is inhibited is correlated with the amount, number, type, and inherent resistance of these substances. Any of these substances may shield microorganisms on items from contact with the sterilant or combine with and inactivate the sterilant.

A. **DEFINITIONS:**

1. Biofilm: A coating containing biologically active organisms that have the ability to develop in water, water solutions, or in vivo, which coat the surface of structures and become trapped within a matrix of organic matter, preventing antimicrobial agents from reaching the cells.
2. Decontamination: Any physical or chemical process that removes or reduces the number of microorganisms or infectious agents and renders reusable medical products safe for handling or disposal.
3. Immediate Use Steam Sterilization (IUSS): A sterilization method that involves the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. Immediacy implies that a sterilized item is used during the procedure for which it was sterilized and in a manner that minimizes its exposure to air and other environmental contaminants. IUSS is the rapid steam sterilization of unwrapped instruments and accessories for immediate use in emergencies or when the only instrument available of its kind is contaminated.
4. Implant: Tissue or material placed within the body with the intent of permanent or long-term retention (i.e., over thirty days).
5. Steam Sterilization: Saturated steam under pressure in a process that destroys all forms of microbial life including bacteria, viruses, spores, and fungi.
6. Liquid Chemical Sterilization (i.e., Peracetic Acid): A method of sterilization used for items that are heat sensitive, can be immersed, are approved for this process by the device manufacturer, and cannot be sterilized using terminal sterilization methods. A peracetic Acid (Steris®) processor is maintained and operated in the Operating Room.

B. **POLICY:**

1. Perform IUSS only when all of the following conditions are met:
   a. The device and sterilizer manufacturer's written instructions for use (IFU) include instructions for IUSS.
   b. The device manufacturer's written instructions for cleaning, cycle type, exposure times, temperature settings, and drying times (if recommended) are readily available and followed.
   c. Items are placed in a containment device that has been validated for IUSS and cleared by the FDA for this purpose and in a manner that allows steam to contact all instrument surfaces.
   d. The rigid sterilization container manufacturer's IFU are followed.
   e. Measures are taken to prevent contamination during removal form the sterilizer and transfer to the sterile field.
2. IUSS of implants shall only be performed in extreme emergency when no other option is available.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/10;8/12; 8/15; 04/20, **04/23**	5/10; 8/12, 9/15, 04/20, **08/23**	8/12, 09/15, 05/20, **08/23**	03/16, 05/20, **09/23**	n/a	06/10; 10/12. 03/16, 06/20, **10/23**	07/20, **12/23**	08/10; 11/12, 04/16, n/a	08/10;12/12, 04/16, 08/20

a. When IUSS of an implant is unavoidable, determine cycle selection by the device manufacturer's IFU and include a biological indicator with the load. A preassembled challenge device may be used.

3. Sterilize reusable medical devices according to manufacturer's IFU for the specific device, packaging, and sterilizer equipment.
   a. When the device, sterilizer, and packaging manufacturer's IFU conflict, follow the device manufacturer's IFU.
4. Decontamination and sterilization activities shall be done in compliance with current infection control standards, state and federal regulations and Tri-City Medical Center policies and procedures.
5. All sterilizers will be operated, monitored and maintained per manufacturer's IFU.
6. All Items will be cleaned and decontaminated prior to IUS.
7. Contain devices processed using IUSS in a rigid sterilization container and transport them to the point of use in a manner that minimizes the risk of contamination of the item and thermal injury to patients or personnel.
8. A challenge pack (including a Class V integrator and biological indicator) will be included in every IUSS cycle. Results of the biological indicator shall be reported to the surgeon and documented in the IUSS logbook.
9. Autoclave doors will be kept closed when not is use.
10. Items processed via IUS shall be used immediately and not stored for future use or held from one procedure to the next.
11. Sterilizer function shall be monitored/tested daily with mechanical, chemical, and biological indicators (as applicable) to meet all of the monitoring parameters established for each type of sterilizer, per sterilizer manufacturer's IFU.
12. Sterilizer logs shall be kept for a period of seven (7) years.

C. **PROCEDURE:**

1. Clean and decontaminate devices prior to IUS, according to device manufacturer's IFU.
2. IUSS:
   a. Place devices in a rigid container designed for immediate use sterilization (i.e., FlashPak).
   b. Include a challenge pack (containing chemical and biological indicators) in the cycle, according to manufacturer's IFU.
   c. Select the appropriate sterilization cycle, according to device manufacturer's IFU. Follow sterilizer manufacturer's IFU to load sterilizer, close door, and select cycle according to load contents. Cycles are:
      i. Cycle 1: 4-minute Prevac Cycle (Express)
      ii. Cycle 2: 4-minute Prevac Cycle (20-minute dry)
   d. At the end of the sterilization process, the staff member who removes the load shall review and initial the print-con strip, and retrieve the challenge pack. At the end of the day the data strip is taped to the sterilizer log sheet as a permanent record.
   e. If any of the parameters (i.e., time, temperature, pressure, completion of cycle) are not reached, the load is not sterile.
      i. Circle the parameters that do not meet the acceptable standard.
      ii. Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR Nursing Leadership or designee of the sterilizer malfunction.
         1) Place tape across the sterilizer door with an "OUT OF SERVICE" sign.
         2) Notify Building Engineering (Ext. 7711).
         3) Enter a Building Engineering Work Order via TCMC Intranet.
         4) In surgery, make note on the schedule board and communicate information at report/huddle.
         5) DO NOT USE the sterilizer until Building Engineering/designee has completed repairs. A major repair requires three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".

iii. Remove devices from sterilizer and reprocess in another sterilizer.
iv. Document in the sterilizer log book that the load was aborted and reprocessed.

3. Liquid Chemical Sterilization (Peracetic Acid)- Steris:
   a. Before use, ensure daily testing of liquid chemical sterilant processing system has been completed.
   b. Assemble clean instruments in the appropriate Steris tray and tray insert, according to manufacturer's IFU.
   c. Obtain appropriate adapter (matched to manufacturer and equipment identification number) and connect to Steris tray and equipment ports, if applicable, as recommended by the manufacturers of both the device and the liquid chemical sterilant processing system. Ensure all ports/lumens of the equipment to be sterilized are attached to a connector.
   d. Include a Steris chemical indicator in each cycle, according to manufacturer's IFU.
   e. Place lid on the Steris tray insert.
   f. Place Steris S40 sterilant container in sterilant chamber and insert aspirating probe according to manufacturer's IFU. Ensure tubing is not kinked.
      i. Follow precautions for safe handling of peracetic acid according to manufacturer's IFU.
   g. Close lid of Steris machine and press START to begin cycle, according to manufacturer's IFU.
   h. Upon completion of cycle, check printout to ensure the cycle has completed and the following sterilization parameters have been met, according to manufacturer's IFU:
      i. Temperature (45.5-60°C)
      ii. Exposure time (6 minutes)
      iii. Concentration (greater than 175)

4. Maintain sterility during transport to the point of use.
   a. IUSS:
      i. Open the sterilizer door cautiously, and prepare to remove the sterilized tray for transport to the operating room.
      ii. Retrieve the challenge pack and read the chemical indicator (i.e., Class V Integrator). If the Integrator did not change color into the "pass" range, the load is not considered sterile and must be run again.
         1) If the indicator line has not moved past the "Accept/Reject" mark, on the second load, place the sterilizer "OUT OF SERVICE".
         2) Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR Nursing Leadership or designee of the sterilizer malfunction.
         3) Place tape across sterilizer door with an "OUT OF SERVICE" sign.
         4) Notify Building Engineering (Ext. 7711).
         5) Enter a Building Engineering Work Order via TCMC Intranet.
         6) In surgery make note on the schedule board and communicate information at report/huddle.
         7) DO NOT USE the sterilizer until Building Engineering has completed repairs. A major repair requires three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".
   b. Steris:
      i. Remove the sterilized tray insert from the Steris machine. Instruments that remain in the covered tray insert are sterile and may be delivered immediately to the point of use. Items may not be stored for later use or held from one procedure to another.
      ii. If applicable, ensure connector is still connected to the equipment before accepting the load.
      iii. Read chemical indicator within 30 minutes of cycle completion, according to manufacturer's IFU.

5. If the item immediate use sterilized was an implant, the nurse retrieves the Biological Indicator and incubates it according to manufacturer's IFU.
   a. Implants sterilized via Immediate Use Sterilization shall be quarantined on the sterile field until results of the BI are obtained.
   b. If a positive test Biological Indicator occurs, immediately notify the surgeon and the Surgical Services Nursing Leadership/designee.
      i. The Surgical Services Director/Assistant Director/designee will notify the implanting physician (if not already aware) and the infection control practitioner.
      ii. The primary circulator must complete a Quality Review Report via the RL Solutions system.

D. DOCUMENTATION:

1. Document every load run in the autoclave on the appropriate Immediate Use Sterilization Log sheet. Information recorded from an IUSS cycle shall include:
   a. Sterilizer number
   b. Date
   c. Operating Room number where the items were used
   d. Name and signature of personnel starting cycle
   e. Name and signature of personnel removing sterilized items at the end of the cycle
   f. Cycle number
   g. Load contents
   h. Identify if load contains implant
   i. Print-Con strip record of cycle parameters (i.e., exposure time, temperature, pressure, vacuum)
   j. Patient Identification label
   k. Class V integrater for IUSS load is affixed to the log sheet
   l. Reason for IUSS
   m. Biological Indicator information, if the load contains an implant:
      i. Incubator well numbers of test ampule and control ampule
      ii. Date/Time/Initials when ampule is placed in incubator
      iii. Date/Time/Initials when test read/completed
      iv. Test results ("+" or "-")
      v. Control results ("+" or "-")
      vi. Lot # of biological indicators
2. Document every cycle run in the Steris, including:
   a. Steris machine ID
   b. Date
   c. Patient identification label
   d. Cycle number
   e. OR suite in which item was used
   f. Item(s) sterilized
   g. Affix processed chemical indicator
   h. Reason for IUS
   i. Initials of person sterilizing item
3. Accurate and complete records are required for process verification, infection control monitoring, and sterilizer malfunction analysis.

E. REFERENCES:

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.
2. Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 6/02

SUBJECT: **Medical Equipment Brought into the Facility**

REVISION DATE: 07/05, 07/07, 03/10, 08/12, 11/16, 12/20

Patient Care Service Content Expert Approval:	~~006/20~~07/23
Clinical Policies & Procedures Committee Approval:	~~07/20~~08/23
Nursinge Leadership~~Executive Committee~~ Approval:	~~08/20~~08/23
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~09/20~~09/23
Medical Executive Committee Approval:	~~10/20~~10/23
Administration Approval:	~~12/20~~12/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/20

A. **POLICY:**
1. To provide guidelines for patient owned/supplied equipment that is brought into Tri-City Medical Center.

B. **DEFINITION:**
1. Patient-Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.).

C. **POLICY:**
1. Tri-City Healthcare District's (TCHD) standard of care is to use hospital-owned equipment whenever possible.
    a. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.
    b. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):
        i. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States.
    c. Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals.
    d. Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:
        i. If the equipment requires audible alarms that cannot be provided.
        ii. If the equipment has alarms that can be defeated without clinical staff intervention.
        iii. If the patient should become incapacitated or is otherwise unable to maintain their equipment, the hospital may provide substitute equipment.

iv. Any reason that TCMC deems reasonable that may place the patient's safety at risk.

2. Upon the patient's request to use PSE, the nurse caring for the patient should explain to the patient that TCHD's standard of care is to use hospital owned equipment whenever possible.
   a. If patient is agreeable to the use of hospital equipment, change the PSE to hospital equipment and send PSE home with family member (if family member available).
   b. If the patient refuses hospital equipment and requests use of PSE, the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.
      i. If the equipment is deemed medically appropriate, the physician will authorize use with an order.
3. Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will:
   a. Verify a physician's order has been obtained and entered in **the electronic health record (EHR)**~~Cerner~~ approving the use of the patient's equipment.
   b. Ensure the patient or legal representative signs a liability waiver (See Patient-Supplied Equipment Waiver) for use of PSE.
      i. The signed waiver shall be placed in the patient's chart.
      ii. If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital.
   c. Visually inspect the PSE (assessing for damage to the device, infestation with insects, excessively soiled.)
   d. Wipe down the PSE with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at extension 5696.
   e. Notify Bio-Med as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (Monday-Friday).
      i. If the device is brought in during the weekend, the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.
      ii. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center, (off hours and weekends contact the Administration Supervisor to notify Bio-Med).
   f. Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.
   g. If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well-being (example: pulse oximeter).
4. For any concerns or questions, please contact:
   a. ~~The Director of~~ Risk Management for risk issues.
   b. ~~The~~ Chief Nurse Executive for patient care issues.
   c. ~~The Management of Clinical Engineering~~**Bio Med** for medical equipment issues.

D. **SPECIAL CONSIDERATIONS:**
1. Insulin Pumps:
   a. See Patient Care Services (PCS) Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient.
2. Wearable Defibrillator:
   a. See PCS Policy: Wearable Defibrillator (LifeVest).

3. Implanted Pain Pumps:
   a. The admitting physician will be notified immediately the patient has an implantable pain pump.
   b. The admitting physician will attempt to contact the original prescribing physician of the pain pump for information on continuing, stopping or disconnecting.
   c. The admitting physician will enter orders regarding the status of the pain pump.
      i. If the medication will continue during hospitalization, the medication that is being infused by the pain pump must be entered into the electronic health record.
         1) This will include the drug, dose, total volume, rate and volume infused.
         2) The order must specify that the drug is infusing through pain pump.
         3) The nurses will document on the electronic medication administration record (eMAR) daily.
4. Ambulatory Infusion Pump (AIP):
   a. The admitting physician will be notified immediately that the patient is wearing an AIP.
   b. Admitting physician will attempt to contact the original prescribing physician of the AIP for information on continuing, stopping or disconnecting.
      i. Admitting physician may also call the number located on the AIP for other information.
      ii. If the medication is a chemotherapeutic agent, the medication must be administered/discontinued by TCHD Chemotherapy Competent Registered Nurse (see PCS Procedure: Chemotherapy Administration).
   c. The admitting physician will enter orders regarding the status of the AIP.
      i. If the medication will continue during hospitalization, the medication that is being infused by the AIP must be entered into the electronic health record.
         1) This will include the drug, dose, total volume, rate and volume infused.
         2) The order must specify that the drug is infusing through AIP.
         3) If the AIP is continued, nurses will document on the eMAR daily.

E. **FORMS:**
1. 7010-1037 Patient-Supplied Equipment Waiver Sample

F. **RELATED DOCUMENTS:**
1. Outpatient Infusion Center Procedure: Ambulatory Infusion Pumps
2. PCS Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient
3. PCS Policy: Wearable Defibrillator (LifeVest)
4. PCS Procedure: Chemotherapy Administration

PATIENT SUPPLIED EQUIPMENT WAIVER

This Patient Supplied Medical Device or Equipment Waiver between Tri-City Healthcare District (Tri-City) and _____ (Patient requesting to utilize patient supplied medical device or equipment or his/her legal representative) is entered into on _____, 20 _____. Patient or legal representative must initial each statement in order to use Patient Supplied Medical Device or Equipment in a Tri-City Healthcare District facility. The conditions set forth herein will expire upon my discharge from the facility in which the agreement is entered into.

Type of Medical Device or Equipment to be used: _____

(Do not use for Insulin Pump, refer to Insulin Pump Policy).

_____ I understand that I have voluntarily brought my medical device/equipment into a Tri-City facility for my use during my stay at a Tri-City facility.

_____ I certify that I have been trained on how to use and repair this medical device/equipment, and that I am fully capable of using and repairing the medical device/equipment.

_____ I understand that Tri-City performed an inspection of my medical device/equipment. This inspection is not a warranty that the medical device/equipment is safe or free from defects. I am not relying on Tri-City's inspection of the medical device/equipment to ensure its safety or my proper use.

_____ I understand that Tri-City may unilaterally determine without warning to me that I may no longer use my medical device/equipment. Tri-City may replace my medical device/equipment with its own medical device/equipment.

_____ I understand that by signing this document, I hereby waive any claim or right of action against Tri-City related to my use of my medical device/equipment. I release Tri-City and its employees, agents, and assigns from any and all liability resulting from the use, operation, damage to, and repair of my medical device/ equipment by myself, Tri-City, and any of its employees.

By agreeing to the above terms and conditions, I expressly assume the risks that may result from bringing a medical device or personal medical equipment to be utilized, into a Tri-City facility. I release Tri-City from any damages, and agree to indemnify, hold harmless, and defend Tri-City, its employees, affiliates, directors, officers, subsidiaries, and agents against any and all liability arising out of the negligent operation or use of the medical device/equipment by me or my family or visitors. I acknowledge and agree that in no event shall Tri-City be liable for any indirect, special, consequential, incidental, or punitive damages, injury, loss, or expense associated with the use of a personal medical device/equipment by me or my family and/or visitors. This agreement shall be legally binding on me and my designated family member(s) and/or visitors operating my personal medical equipment. My signature below indicates I have read this agreement, understand it, and agree to be bound by its terms.

Patient or Legal Representative _____ Date / Time (a.m./p.m.) _____

Witness _____ Date / Time _____

Affix Patient Label

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

7010-1037
(Rev. 11/13)

PATIENT SUPPLIED EQUIPMENT WAIVER

White - Hospital Canary - Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**09/05**	**SUBJECT:**	**Medication Reconciliation**
REVISION DATE~~(S)~~:	**06/03, 05/05, 04/09, 07/12, 01/17 09/18**		

Patient Care Services Content Expert Approval:	**~~12/17~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~05/18~~05/23**
Nursing Leadership Approval~~e Executive Council~~:	**~~07/18~~06/23**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~07/18~~07/23**
Medical Executive Committee Approval:	**~~08/18~~10/23**
Administration Approval:	**~~09/18~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **DEFINITIONS:**

1. **Medication Reconciliation: Medication Reconciliation is the process of comparing the medications a patient is taking with newly ordered medications in order to ensure accuracy in the list of the patient's current medications at each change of level of care or at discharge.**
2. **~~1.~~Medication History: The first step to performing a medication reconciliation is to obtain a detailed, accurate, and complete list of all prescribed and non-prescribed medications a patient is currently taking.**

B. **POLICY:**

1. Medication reconciliation is an interdisciplinary process between the physician, patient, nurse and pharmacy designed to decrease medication Adverse Drug Events/Adverse Drug Reactions (ADE/ADR) and ensure accuracy in the list of the patient's current medications at each change in level of care or at discharge.
2. All Inpatients shall have all medications reconciled within 24 hours of admission. The final outcome of medication reconciliation is to obtain and document a complete and accurate list of the patient's current medications upon the patient's admission to the organization.
3. The most up to date, reconciled medication list is provided at all transitions of care.
4. When the patient is discharged, the reconciled list of medications is explained to the patient and the process documented.
5. The final reconciled medication list is ~~faxed~~ **communicated** by Medical Records to the primary care provider (PCP) or other physicians that will follow up with the patient after discharge.
6. A good faith effort will be made to perform a modified medication reconciliation process in a non-twenty-four hour setting and includes different patient circumstances, such as the confused, unconscious or observation status.
   a. A good faith effort to collect a home medication list (medication history) will be made, but does not require dose, route, and frequency
   b. Outpatient imaging intravenous ~~iodinated~~ contrast studies.
      i. For diabetic patients on oral diabetic medications, this list (medication history) is **reviewed for contraindicated medications.** ~~scanned to the pharmacy which is then reviewed by the pharmacist.~~
      ii. At the end of an outpatient encounter, patients will be taught the importance of managing their diabetic medication.

C. **PROCESS:**

1. All medications shall be reconciled upon:
   a. Admission
   b. Intra-facility transfer (change in level of care)
   c. Discharge
2. The nurse **or ~~Medication History Technician (MHT)~~ pharmacy personnel** shall review and complete a medication history. Every effort will be made to obtain drug name, dose, frequency and route. At a minimum, drug name will be obtained.
   a. The patient's medication history may be obtained from either the patient, family members, caregiver and/or legal representative or from an alternate source (for example Surescript) if consent is obtained as needed.
      i. If the patient, family, or legal representative is able to provide accurate data, no additional source of information is required.
   b. In cases when neither the patient nor the family is considered a reliable source, alternative sources shall be located. Consider the following:
      i. Alternate source such as Surescript database if consent obtained as needed
      ii. Review the patient's current medical record
      iii. Contact the patient's current pharmacy to determine or validate his/her current medications
      iv. If patient was admitted from a care facility, contact previous care facility to verify the patient's current medications.
   c. Justice Involved Patient- Medication list (medication history) will be obtained from the correctional institution not from the patient.

~~3. Pharmacy personnel may assist with the medication reconciliation process as a resource.~~

~~4.~~**3.** The Admitting Physician/Allied Health Professional (AHP) ~~is~~ required to review, complete and reconcile, ~~A~~admission ~~M~~medication ~~Reconciliation~~ **History** information in the electronic health record collected upon admission of the patients within 24 hours.
   a. Once Admission Medication ~~Reconciliation~~ **History** List has been completed and all medications reconciled, the complete list of the patient's medication**s** ~~(MAR)~~ shall be used as the most complete and accurate medication list.

~~5.~~**4.** If new information is later obtained, the physician/AHP or nurse may update the medication history in electronic health record (EHR).

~~6.~~**5.** Intra-Facility Transfer (Change in Level of Care):
   a. All medications will be reviewed and revised as appropriate when the patient is being transferred to the next level of care
      i. The physician/AHP will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.

~~7.~~**6.** Discharge:
   a. All medications will be reviewed against home medications to create a final discharge medication list
      i. The physician/AHP will complete the discharge medication reconciliation in electronic health record (EHR) and will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
         1) Prescriptions to be completed, including but not limited to:
            a) ePrescribe – electronic prescription transmitted to the patient's pharmacy
            b) Printed on the unit and handed to the patient
            ~~c) Handwritten on personal (physician's) prescription pad~~
   b. The nurse shall print and deliver the Patient's Discharge Instructions, which includes the reconciled medications to the patient and/or family. Education will be provided on any new medications that are ~~being~~ ordered for the patient.
   c. Medical Records shall send a Transition of Care form which includes the discharge medications to the attending physician/AHP and consultant(s) listed in the patient's

medical record the day following discharge. This final step in the medication reconciliation process ensures the physicians/AHPs are notified of the list of medications and other instructions given to the patient upon discharge.

d. Justice Involved patients will follow progressive care discharge process.

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

1. Patient Care Services Policy: Physician/Allied Health Professionals (AHP) Inpatient Orders
2. Patient Care Services Policy: Transfer of Patients, Intra-Facility

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) SCREENING

I. POLICY:

A. Function: To describe the process for screening patients for MRSA.

B. The following patient populations admitted to Tri-City Healthcare District (TCHD) shall be tested for MRSA during pre-registration process or within 24 hours of admission:
   1. The patient has been discharged from a general acute care hospital within thirty (30) days prior to the current hospital admission.
   2. The patient will be directly admitted to the Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU).
      a. This includes patients transferred into ICU from other medical units and neonates transferred into NICU from other hospital facilities.
   3. The patient is receiving inpatient dialysis.
   4. The patient is transferred from a skilled nursing facility (SNF).

C. The physician/Allied Health Professional (AHP) will decide to screen any patients who show evidence of increased risk invasive MRSA be screened for MRSA prior to discharge.

D. The physician/AHP must order the screening test and the physician/AHP or authorized designee, will be responsible to provide oral and written instructions regarding aftercare and precautions. (SB 1058, section 3, 1255.8, 4c and 4d)

E. When requested by the Infection Prevention and Control Department, Periodic Prevalence Studies may be performed to identify previously unknown colonized patients.

F. See Infection Control Policy: Management of Patients with multi-drug resistant organism (MDRO) and/or C. Difficile Infection for additional information.

II. PROCEDURE:

A. During the patient history/data collection the nurse shall determine if the patient meets the circumstances described above and shall record that information in the patient's medical record.
   1. Documentation of the circumstances listed above will generate a task for nares cultures to rule out MRSA.

B. The nurse shall obtain cultures when indicated within 24 hours of admission and send to the TCHD lab for processing.
   1. Nares cultures
      a. Swab both nares with attention to swabbing the anterior portion of the nares.
         i. For adult patients, use one culturette swab for both nares.
         ii. For pediatrics patient, use one culturette swab for both nares.
         iii. For neonates, use one nasopharyngeal swab for both nares.
      b. Swab nose using same swab to both nostrils being careful not to touch outside of nose.
      c. Insert swab ½ – 1 inch into nares gently rotating swab in a clockwise then counter clockwise two (2) to five (5) times pressing gently into the nasal septum.
      d. Return swab into transport medium being careful not to touch sides of container.
      e. Label the culture in accordance with Patient Care Services Procedure: Specimen Handling and include "rule out MRSA," this allows the lab to screen for only this organism.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter-disciplinary Practice Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/08, 06/10, 05/12, 01/15, 11/17, 09/18, **12/22**	05/12, 02/15, 02/18, 09/18, 03/20, **01/23**	05/12, 02/15, 03/18, 11/18, 04/20, **02/23**	04/18, 04/20, **04/23**	05/12, 03/15, 05/18, 05/20, **05/23**	05/12, 05/15, 01/21, **07/23**	07/12, 06/15, 07/18, 07/21, **10/23**	08/21, **12/23**	07/15, n/a	07/12, 07/15, 08/21

C. TCHD's clinical microbiology lab shall process nares cultures received to "screen for MRSA".
   1. If the patient's screening test is positive for MRSA:
      a. Pre-printed MRSA education shall be provided to the patient or the patient's representative.

III. DOCUMENTATION:

A. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record
   1. Not required if a screening process triggers the order

IV. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current unencumbered California RN
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annual

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medical Staff Committees to include, but not limited to the Interdisciplinary Committee, and Administration.
B. Review: Every two (2) years.

VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform MRSA screening.

VII. RELATED DOCUMENT(S):

A. Patient Care Services Procedure: Specimen Handling
B. Infection Control Policy: IC 5 Standard and Transmission Based Precautions
C. Infection Control Policy: Management of Patients with Multi-Drug Resistant Organism (MDRO) and/or C. Difficile Infection

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/86**	**SUBJECT:**	**Organ Donation, Including Tissue and Eyes**
REVISION DATE~~(S)~~:	**01/90, 04/94, 03/97, 07/03, 10/05 07/07, 05/08, 01/11, 08/11, 01/16 08/19, 08/20**		

Patient Care Services Content Expert Approval:	**~~03/20~~08/23**
Clinical Policies & Procedures Committee Approval:	**~~05/20~~09/23**
Nursing Leadership Approval:	**~~06/20~~10/23**
Medical Staff Department or Division:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/20~~10/23**
Administration Approval:	**~~07/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
1. This policy provides staff with guidance for:
   a. Recognition of imminent death and provision of patient and family care needs.
   b. The hospital's obligations for the referral of potential donors for organ, tissue, and eye donation.
   c. Delineation of the hospital's responsibilities and the Organ Procurement Agency's responsibilities in completing the referral and donation of anatomical gift process.
   d. The management of potential donors to include billing responsibilities.

B. **DEFINITIONS:**
1. Anatomical Gift: Donation of all or part of a human body to take effect upon or after death. Donation categories are as follows:
   a. Organ Donor:
      i. A brain dead individual whose cardiopulmonary function is being artificially maintained for the purpose of solid organ donation.
      ii. An individual whose organ(s) can be recovered for transplant after the heart has stopped (Donation after Circulatory Death/DCD.)
   b. Tissue Donor: Brain dead or cardiac dead individual who may donate their skin, heart valves, bone or cartilage.
   c. Eye Donor: Brain or circulatory dead individual who may donate their eyes.
2. Imminent Death: Anticipated death of a patient on a ventilator or potentially brain dead. Guidance for determining imminent death include the following:
   a. A ventilated patient with a devastating illness or injury who is in Intensive Care Unit or Emergency Department; and, in addition has one of the following:
      i. Clinical findings that are consistent with a Glasgow Coma Scale (GCS) that is less than or equal to 4 (<4) without sedation or paralytics; or:
   b. For whom physicians are evaluating a diagnosis of brain death; or
   c. For whom a physician is considering that life-sustaining therapies be withdrawn, pursuant to the family's decision.
   d. Reference Patient Recognized as Imminent Death Flowchart
3. Brain Death: An irreversible cessation of all functions of the entire brain, including the brain stem. (Health and Safety Code Section 7180). A physician may determine an individual has

suffered brain death (as defined by statute.) Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code Section 7181.) Refer to PCS Policy: Determination of Brain Death for complete details.

4. Circulatory Death: Irreversible cessation of cardiac and respiratory functions. Declaration of death will be determined when there is no palpable pulse, no heart beat by auscultation (mechanical heart beat), and no respiratory efforts. A five minute wait period is required to confirm cessation of vital functions to declare circulatory death.
5. Designated Requestor: Staff from the Organ Procurement Agency, Lifesharing or the San Diego Eye Bank or their representative who has completed appropriate training. Training includes the methodology for approaching potential donor families and informed consent process for requesting organ, tissue and eye donation.
6. Organ Procurement Organization (Agency): Lifesharing has been designated by the United States Department of Health and Human Services (DHHS) as the organ procurement agency for San Diego and Imperial Counties within the meaning of 42 C.F.R. 486.301 et. Sew.; is a member, in good standing, of the Organ Procurement and Transplantation Network established under the Act; and is a certified member, in good standing, of the American Association of Tissue Banks.
7. ~~CDCR: California Department of Corrections and Rehabilitation~~
8. ~~SDSD: San Diego County Sheriff Department~~

C. **POLICY:**

1. Tri-City Medical Center (TCMC) recognizes that patients and families facing imminent death have special needs and to the extent possible, will be afforded any reasonable religious or cultural practices surrounding the issue of death. Families or next of kin will be afforded time to gather family or next of kin at the patient's bedside and understand the diagnosis and treatment options as well as the patient's right to donate or not donate organ and tissues.
2. TCMC is committed to ensuring that every individual or family of a potential donor in collaboration with Lifesharing (Organ Procurement Organization) is informed by a designated requestor of their option to donate organs or tissue or not to donate. Additionally, Lifesharing, San Diego Eye Bank and TCMC are dedicated to educating staff of donation issues and are accountable for the Organ Procurement Program effectiveness.
    a. Lifesharing is the federally designated organ procurement agency for TCMC. Lifesharing has:
        i. Consulted with the San Diego Eye Bank and developed a protocol for identification and notification of potential eye donors.
        ii. Specified the San Diego Eye Bank as an appropriate third party for death notification on potential eye donors.
    b. Hospital obligations at time of death and imminent patient death:
        i. Make a reasonable search for a document of anatomical gift or donation, e.g. advance directive, statement attached to driver's license, or other information specifying refusal of donation, if there is not immediately available any other source of that information.
        ii. Refer to Lifesharing, in a timely manner, of all deaths and imminent deaths that occur in the hospital (regardless of the deceased's medical suitability for organ donation and regardless if patient is in **California Department of Corrections and Rehabilitation** (CDCR) or **San Diego County Sheriff Department** (SDSD) Forensics/Custody.
            1) Neonatal death defined as live birth delivery requiring death certificate is reportable.
        iii. Miscarriage/abortion or fetal deaths are not reportable.
    c. Lifesharing staff/representative, as Designated Requestors, are responsible for approaching potential donor families and obtaining authorization in the process of requesting organ, tissue and eye donation.

d. Lifesharing will ensure there is a diligent search for a legal representative or evidence of an individual's wishes regarding donation. If a search does not reveal a legal representative or documentation of wishes, a release from the Medical Examiner Office will be obtained and the Hospital Risk Manager contracted to facilitate donation authorization from hospital administration.

3. All healthcare providers will display discretion and sensitivity with respect to the circumstances, views, wishes, and beliefs of the families of potential donors.
4. Lifesharing shall monitor and provide reports of eligible organ donors and organ donor conversion rates for inclusion in the hospital performance improvement activities.

D. **RESPONSIBILITIES:**

1. Hospital
   a. Primary nurse or physician must notify Lifesharing referral service of all imminent deaths as soon as possible, and within one hour of circulatory death.
      i. Nurse/physician is not responsible for screening potential donors. This is the responsibility of Lifesharing or its designated representatives, such as the San Diego Eye Bank.
   b. At the time of referral, provide the following information:
      i. Name and medical record number
      ii. Age/Sex/Race
      iii. Height and weight
      iv. Time and cause of death (for circulatory death)
   c. Document all referrals including imminent deaths on Expiration Record in Cerner or if necessary on a hard copy Release of Deceased form. (Refer to Patient Care Services Procedure Manual, Release of Deceased) Documentation includes:
      i. Date and time of referral
      ii. Name of person contacted at Lifesharing
      iii. Referral number (when provided by Lifesharing)
      iv. Determination by procurement agency
      v. Either:
         1) Patient was declined as donor; or
         2) Agency will further evaluate patient as a potential donor and approach the family for donation.
2. Ensure families are not approached regarding potential donation until:
   a. Attending physician (or his/her representative) has informed family of patient's irreversible condition, brain death or imminent death.
   b. Circulatory death has occurred and patient's death has been reported via donor referral service.
3. Family Notification of Donation Options and Discussion:
   a. The health care team members should not initiate the donation discussion with the family. Health care team member having a relationship with the patient or family should, when possible, collaborate with, and facilitate the discussion between the Lifesharing Designated Requestor and the family regarding options for organ and tissue donation.
   b. If the patient's family initiates discussion regarding donation, Lifesharing will be notified immediately and the family informed that all their questions can be fully answered by staff from Lifesharing or the San Diego Eye Bank. Lifesharing or the San Diego Eye bank shall notify the nurse or physician of the potential donor's suitability for donation.
   c. Upon notification by Lifesharing and/or the San Diego Eye Bank that the potential donor is found to be registered on the Donate Life California Organ and Tissue Donor Registry, collaborate with them to confirm:
      i. The identity is correct per the legal decision maker
      ii. Plans are consistent with any expressed wishes in a valid document pursuant the Uniform Anatomical Gift Act (UAGA) as defined in California Law (CA H&S 7150), and the Motor Vehicle Code (CA MVC 12811), an anatomical gift, that is

not revoked by the donor before death, is irrevocable and does not require authorization or concurrence of any other person after the donor's death. This includes an anatomical gift that is made by means of and/or is registered in the California Organ and Tissue Donor Registry or other State registry designated by law.

iii. In circumstances of preauthorization by the patient, support Lifesharing efforts with sensitivity and cultural consideration, to communicate to the legal decision maker, the plans to proceed with donation.

4. Physician
   a. The medical management of the patient prior to brain/circulatory death remains the responsibility of TCMC attending physician. Medical Management to ensure organ viability will be continued until Lifesharing confirms suitability and options have been presented to the family.
   b. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of an organ/tissue that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.
5. Lifesharing
   a. Screen each referred patient based on current medical criteria for organ, tissue and eye donation. Lifesharing will refer circulatory dead patients to the appropriate agency for screening for potential eye and tissue donation.
   b. The "Designated Requestor" (in collaboration with the health care team when possible) will initiate contact with family about donation options and obtain authorization from the legal decision-maker upon report of death, imminent death or brain death.
   c. Collaborate with the primary physician to provide physiological maintenance while suitability for donation is being evaluated. The cost associated with a procedure required or medication given solely for the purpose of maintaining organ viability for donation will be assumed by Lifesharing.
   d. Document authorization on Lifesharing Form "Authorization for Organ and Tissue Donation".
      i. Authorization may be obtained via telephone utilizing recording device, a hospital staff witness or a recorded line.
      ii. Provide family with a copy of the authorization form.
      iii. Place original copy of the authorization form in the patient's medical record.
   e. Screen all deaths for Medical Examiner criteria and obtain consent from the Medical Examiner for donation, if applicable.
   f. Inform the Medical Examiner of the intent to pursue Donation by Circulatory Death.
   g. Advise hospital staff of suitability for donation and subsequent steps to follow, i.e. implement corneal protective measures or provide the reason for the patient being declined as a donor.
   h. Schedule the donation procedure with the Surgery department, including which organs are planned for donation.
   i. Update nurses, physicians, operating room staff and others as appropriate for status of donation.
   j. Document all events, procedures and donor management in the medical record.
   k. Notify appropriate hospital staff of final outcome of referral.

E. **PROCEDURES:**

1. Primary nurse in collaboration with or the physician must notify Lifesharing referral service by calling 1-888-4ADONOR (1-888-423-6667) for all circulatory deaths within one hour and in the

case of recognition of imminent death, as soon as possible, ideally within one hour. (See Patient Identified as Imminent Death Flowchart)

2. Management of Brain Death Donation (See Brain Death Donation Option Flowchart).
   a. Once family is informed of brain death, assess and document in plan of care spiritual, cultural needs and accommodate as possible. Encourage family/health care decision maker to obtain as much information as possible from the clinical staff to understand the diagnosis and prognosis provide family reasonable brief period of time (generally not greater than 24 hours) to gather family/next of kin at bedside and agree to discontinuation of cardiopulmonary support.
   b. Primary nurse and physician will collaborate regarding status of potential donor and confirmation of brain death diagnosis with Lifesharing.
   c. Refer to the Lifesharing Catastrophic Brain Injury Guidelines at Lifesharing's website at http://www.lifesharing.org.
   d. Primary nurse will assist Procurement Coordinator to maintain potential internal organ donors on support systems until recovery of organs can occur in the operating room.
3. Management of the process for Donation after Circulatory Death (See Circulatory Death Donation Option Flowchart)
   a. A note by the physician, documenting the decision to withdraw life supporting therapy must be placed in the chart prior to requesting decision to withdraw life sustaining treatment or advise the family or hospital regarding medication used or procedure for withdrawal of support.
   b. Lifesharing is notified to determine suitability for the purpose of establishing donation options to be offered to the family.
   c. Care staff allows family time to plan end of life care decisions, autopsy, and timing of withdrawal, palliative care options, and spiritual care.
   d. Lifesharing Designated Requestor advises the family of donation options. Family selects option and Lifesharing obtains all required authorizations. If the family does not select any donation option, the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
   e. If the family authorizes the option of donation after circulatory death, the hospital care team will continue to provide the treatment to optimize organ viability until life sustaining measures are withdrawn. This may include line placement, laboratory testing, medications to improve organ function and reduce possibility of infection, and procedures to establish organ suitability, i.e. bronchoscope, x-rays, ultrasound, CT scan. All procedures and invasive studies and heparin will require separate authorization from the family and orders from the physician of record.
   f. Plan with the family when and where life support will be discontinued and transfer patient as necessary. Consider accommodations for the family as requested. Withdrawal of life sustaining treatment will proceed as agreed upon by the family and care team.
   g. Lifesharing personnel will be available to support the family and act as official time keeper for organ viability. This may include the presence of the Lifesharing Coordinator during withdrawal of life support. Lifesharing surgeons will not be present during withdrawal of life sustaining treatment.
   h. After circulatory death is declared, includes a five minute wait period to confirm cessation of vital functions by a physician or nurse with validated competency (not associated with the procurement team or a hospital transplant team), organ recovery will proceed as directed by Lifesharing team.
   i. If circulatory death does not occur within the timeframe for viable recovery, likely not to exceed two (2) hours, of the withdrawal of life support, the organ recovery plan will be terminated and the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
4. Management of Potential Eye Donor
   a. Implement corneal integrity protective measures:
      i. Close eyelids;

ii. Elevate head;
iii. Place light eye packs over closed eyelids within two (2) hours of death. Be sensitive to the family. This may be done after the family has left.

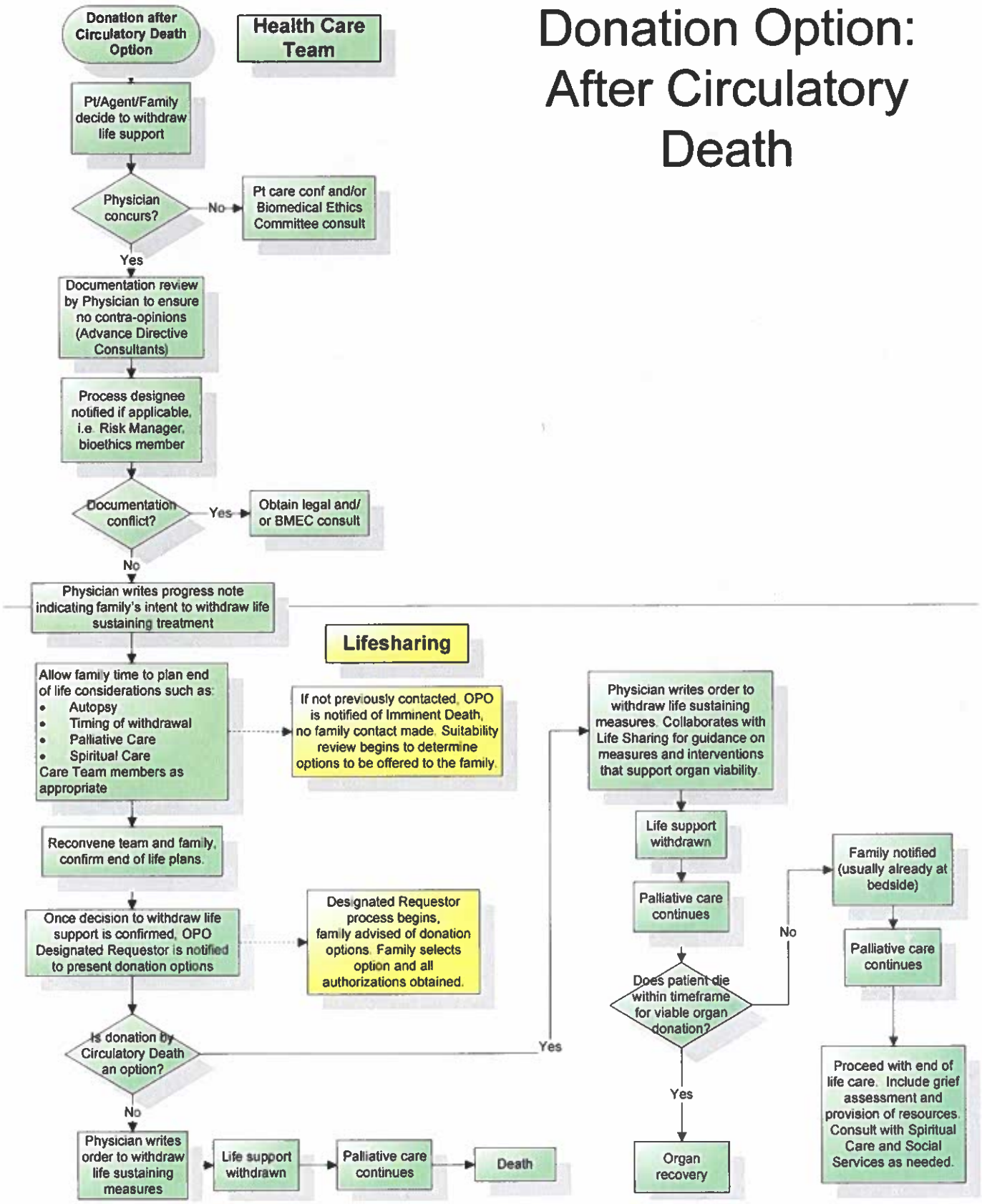
5. Billing Process
   a. No charges related to organ, tissue or eye donation will be billed to the donor, the donor's family or estate, or donor's third party payer. The appropriate recovery agency will assume all charges related to donation.
6. Organ Procurement Program Effectiveness
   a. Health Information Department will, on monthly basis or as requested, provide Lifesharing with the following data:
      i. Patient name
      ii. MR number
      iii. Admit date
      iv. Date of Birth
      v. Date of death
      vi. All ICD10 diagnoses assigned to patient during hospitalization
   b. Lifesharing will review records on a monthly basis, or as needed, to evaluate referral effectiveness of imminent and actual deaths for the opportunity of organ and tissue donation.
   c. Lifesharing will analyze data and provide organ donor conversion rates to the hospital as requested.
   d. Lifesharing will collaborate with performance improvement representatives to analyze data and identify actions to improve process where applicable.

F. **RELATED DOCUMENT(S):**
1. Donation Option: After Circulatory Death Flowchart
2. Donation Option: Brain Death Flowchart
3. Patient Recognized as Imminent Death Flowchart

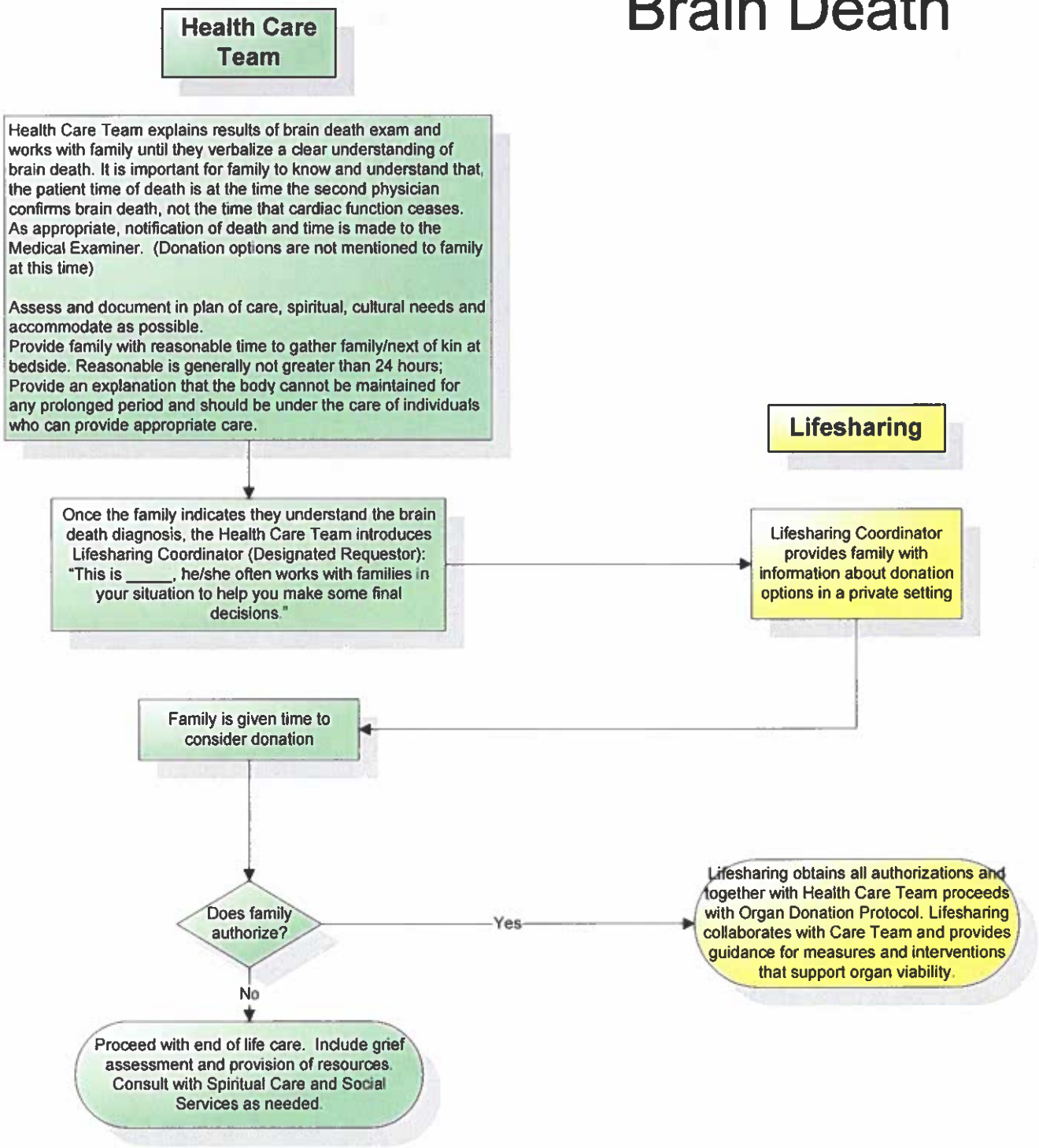
G. **EXTERNAL LINK(S):**
1. http://www.lifesharing.org

H. **REFERENCE(S):**
1. 42 CFR 482.45
2. American Academy of Neurology, current evidenced-based guidelines for Determining Brain Death
3. California Hospital Association, Consent Manual, Current Edition
4. California's Uniform Anatomical Gift Act (Health and Safety Code Sections 7150-7156.5, 7184. 1254/4
5. Lifesharing website: www.lifesharing.org
6. Physiologic Maintenance of Patients with Catastrophic Brain Injuries (Lifesharing)
7. San Diego Eye Bank website: www.sdeb.org
8. Section 9318 OBRA Hospital protocol

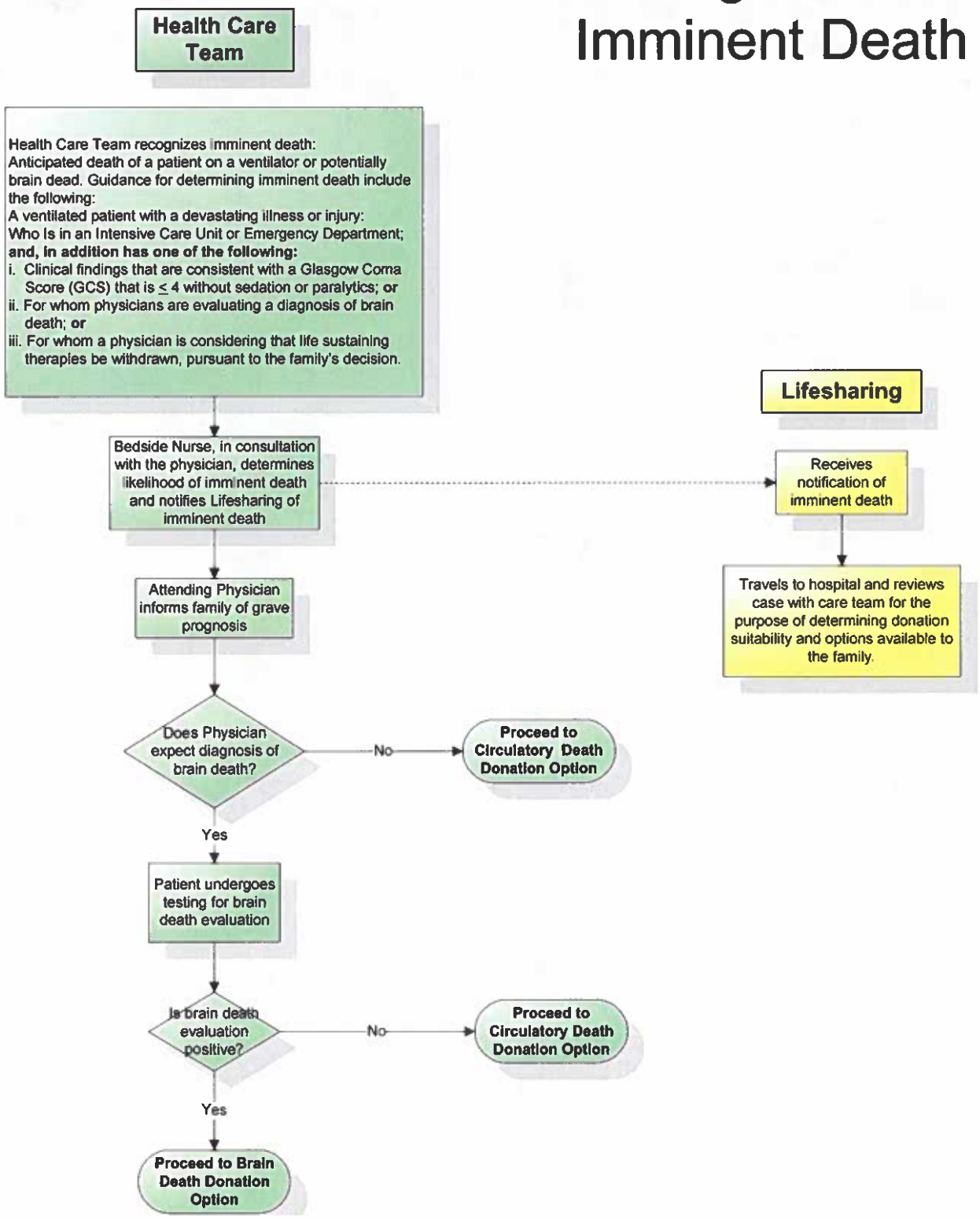
Donation Option: After Circulatory Death



Donation Option: Brain Death



Patient Recognized as Imminent Death



Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/93 **SUBJECT: Pain Management**

REVISION DATE(S): 05/94, 08/97, 09/00, 07/03, 05/05, 04/06, 11/07, 04/08, 11/08, 12/08, 01/12, 11/14, 07/15, 11/18

Patient Care Services Content Expert Approval:	**~~11/17~~04/23**
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Department of Anesthesiology:	**~~05/18~~10/23**
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Board of Directors Approval:	**11/18**

A. **PURPOSE:**

1. To use effective pain management techniques to provide appropriate pain relief designed for each patient on an individual basis.

B. **POLICY:**

1. Pain management begins with the assessment of the patient's level of pain at the time of admission, continues throughout their stay, and is considered in discharge planning.
   a. Perform a pain assessment with each patient report of new or different pain.
2. Pain management is an interdisciplinary process.
3. All patients have a right to pain relief and ~~shall~~**should** receive pain management.
4. The patient (including neonatal, pediatric, adolescent, and adult) and family/caregiver are educated about the following as appropriate to his/her condition and assessed needs for understanding:
   a. Pain
   b. Risk for pain
   c. Importance of effective pain management
   d. Pain assessment process
   e. Methods for pain management
5. Patient ~~shall~~**should** be assured of adequate pain management.
   a. Information ~~shall~~**should** be obtained from the patient and/or family/caregiver as appropriate with regard to cultural, ethnic, and/or religious preference in determining methods of pain management (e.g. pharmacologic versus non-pharmacologic).
6. Assessment and reassessment of pain level and pain relief ~~shall~~**should** be performed with routine vital signs and as needed. Findings ~~shall~~**should** be documented in the electronic health record (EHR).
7. All patients will be assessed for sedation prior to administration of opiates. The Registered Nurse (RN) should also consider concurrent medications that the patient is receiving that can cause an increased sedative effect (i.e., muscle relaxers, tramadol, benzodiazepines and antihistamines).
8. Health care providers ~~shall~~**should** maintain patient safety while managing the patient's pain.
9. An appropriate pain rating scale ~~shall~~**should** be used to assess pain that is consistent with the patient's age, condition, and ability to understand.

C. **PROCEDURE:**

1. Provide a calm, supportive **environment**~~atmosphere~~.
2. Assess patient's characteristics of pain consistent with the patient's age, condition, and ability to understand (may include but is not limited to*):*
   a. Acceptable pain level
      i. If patient is unable to verbalize acceptable level, document reason in the EHR.
      ii. If condition changes and patient is able to verbalize acceptable pain level, the level must be documented.
   b. Physical, behavior, and emotional signs and symptoms of pain
      i. Presence of pain
      ii. Physical exam and observation of pain site as clinically indicated which may include intensity, location, quality, duration, alleviating factors and/or aggravating factors.
   c. An appropriate starting dose should be based on the severity of the pain, the age and condition of the person, and the particular properties of the medication
   d. Anticipation, prevention, and management of common side effects
   e. Consideration of morphine milligram equivalents (MME) to gauge the risk of abuse and overdose potential when treating chronic pain.
3. Document pain assessment in the EHR.
4. For opiates, document pre and post-intervention sedation level using the appropriate sedation scale (see Sedation Evaluation Resource Guide).
5. Call the physician/Allied Health Provider (AHP) for clarification when multiple pain medications are ordered for the same patient without a designated pain level (see Patient Care Services Policy: Medication Administration).
   a. Pain levels are defined as:
      i. Mild pain (pain level 1 – 3)
      ii. Moderate pain (pain level 4 – 7)
      iii. Severe pain (pain level 8 – 10)
6. Perform appropriate interventions based on the patient's stated pain level as needed to achieve patient's acceptable pain level.
   a. Pharmacologic interventions require a physician/AHP order.
   b. Non-pharmacologic interventions that do not require a physician/AHP order may include the following:
      i. Children, adolescents, adults:
         1) Distraction
         2) Positioning
         3) Relaxation
         4) Music therapy
         5) Guided imagery
         6) Massage
         7) Range of motion
         8) Heat or cold therapy
      ii. Infants:
         1) Swaddling
         2) Holding
         3) Repositioning
         4) Pacifier
         5) Oral Sucrose
   c. Non-pharmacologic interventions that require a physician /AHP order may include the following:
      i. Mechanical devices providing heat or cold therapy
      ii. Transcutaneous Electrical Stimulation (TENS)

d. Reassessment of pain level and level of consciousness ~~shall~~**should** be completed after each pain management intervention (pharmacological and non-pharmacological) once a sufficient time has elapsed for the treatment to reach peak effect (within two [2] hours of intervention - goal: 30 minutes for intravenous [IV], 60 minutes for PO/IM, and 15-60 minutes for non-pharmacological). Document PRN response in EHR.
   i. In the Post-Anesthesia Care Unit **and Emergency Department**, when pain medication is ordered more frequently than 30 minute intervals ~~(i.e. every five (5) minutes)~~, the nurse will document the effectiveness after the last dose given.

e. Opiate related side effects (i.e., sedation) should be re-assessed prior to IV or PO pain intervention to determine if patient is eligible to receive the medication.

f. Notify the physician/AHP if pain is not relieved within one (1) hour and no other interventions are available to the patient.
   i. If the patient refuses pain intervention measures/procedures, the care provider ~~shall~~**should** discuss the patient's pain management goals with the patient and reassess potential interventions. Refusal of pain management intervention, reassessment findings, and discussion with patient regarding pain management ~~shall~~**should** be documented in the **electronic health**~~medical~~ record.

g. Notify the physician/AHP if patient continues to report unacceptable pain level, but is not eligible to receive additional interventions due to excessive sedation.

7. Educate patient regarding pain management and document education in the EHR.
   a. The Patient's Rights Regarding Pain Control document is located in the Patient Handbook.

8. Consider patient/family preferences, as well as cultural, ethnic, and religious beliefs, when determining the pharmacological and non-pharmacological methods to be used for pain management.

D. **SPECIAL CIRCUMSTANCES:**

1. Assess for existence of special circumstances (elderly, aphasia, dementia, mental disabilities, age, coma, and end of life), which require modification of traditional approaches to assessment; in the patient with known pathology or behavior that indicates the presence of pain.
   a. Pain in the elderly
      i. Allow patient to use appropriate aids he/she requires for seeing/hearing
      ii. Be aware that pain perception does not decrease with age
      iii. Be aware that metabolism of drugs will decrease with age and lower starting doses may be warranted
   b. Pain in pediatric and newborn patients
      i. Consider using pain faces (Wong-Baker scale)
      ii. Consider using NPASS (Neonatal Pain, Agitation, and Sedation Scale)
      iii. Use NIPS scale neonatal-infant Pain Scale
   c. Pain in the non-English speaking or sensory impaired patient
      i. Refer to Patient Care Services Policies: Communication with the Sensory Impaired and-or Persons with Language Barriers and Interpretation and Translation Services.
   d. Denial of pain in the patient with known pathology or behavior indicating the existence of pain
      i. Explore possible causes, attempt to find solutions or provide information to help patient choose better level of pain control
      ii. Consider a trial dose of analgesic
   e. Pain in patients with impaired communication (coma, severe emotional disturbance, dementia, or with end stage diseases)
      i. Include family or close caregivers in making determination regarding patient's pain level, consider using Proxy Pain Rating.
      ii. Consider a trial dose of analgesics, or other form of intervention if pain is suspected.

iii. Observe systematically for possible pain behaviors related to vocalizations, facial expressions, behavior changes, and autonomic responses
iv. Utilize presumptive treatment of pain for patients who cannot speak and who undergo painful treatments or procedures.
v. Utilize a non-verbal pain scale (for example **Nonverbal Pain Scale [**NVPS**]** or **Checklist of Nonverbal Pain Indicators [CNPI]** or **Critical Care Pain Observation Tool [CPOT]**)

f. Opiate-related side effects (i.e. sedation) must be assessed and re-assessed in all of the above patient populations.

2. Determine patient's ability to manage pain and/or appropriateness of treatment modality (e.g. Patient Controlled Analgesia [PCA]).

E. **SAFETY:**

1. Patients receiving PCA:
   a. Discontinue PCA in patients with deteriorating level of consciousness and notify the physician/AHP.
   b. Instruct family/caregivers to report patient's pain or inability to use PCA to the nurse. Family/caregivers should not push PCA button for patient.
2. Inspect all of patient's medications and identify those with potential to cause sedation (e.g. opiates, benzodiazepines, anticonvulsants, etc.). Use all sedating medications with caution as their effect may be additive.
3. Clarify any supplemental pain medication ordered by physician/AHP other than ~~anesthesiologist~~**anesthesia provider** with the ~~anesthesiologist~~**anesthesia provider** before administration in patients receiving intrathecal or epidural opioids.
4. Monitor the use of ice or heat therapy and the use of transcutaneous electrical nerve stimulation (TENS) patches at least every four (4) hours for the development of burns and/or skin breakdown.
5. Inspect site of fentanyl patches every shift for evidence of inflammation.
6. Observe patients who are receiving a narcotic/opioid for excessive sedation following administration.
   a. Naloxone should be readily available to antagonize enough narcotic so that the patient is able to maintain adequate ventilation but leaves enough opioid available in the system to relieve pain.
7. Avoid abrupt discontinuation of an opioid in a known or suspected physically dependent patient.
8. Regulate all continuous IV pain medications on an infusion pump.
9. Notify physician/AHP for any unrelieved pain.
10. Report to the physician/AHP any signs/symptoms of over sedation or any other unexpected physiological and behavioral outcomes:
    a. Apnea
    b. Respiratory rate less than ten (10) breaths per minute or less than twenty (20) breaths per minute for children under two (2) years of age
    c. SpO_2 less than 92% or as ordered
    d. Hypotension
    e. Allergic reactions
    f. Change in level of consciousness (e.g. unresponsive, somnolent, difficult to arouse)
    g. Nausea/vomiting
    h. Itching
    i. Urinary retention
    j. Absent bowel sounds

~~F. COMPETENCY AND PROFESSIONAL DEVELOPMENT:~~
~~1.~~

~~G.~~F. **QUALITY INDICATORS AND PROGRAM EVALUATION:**

1. **Quality indicators are defined, and the program is evaluated to improve the quality and safety of pain management and patient outcomes.**
2. **Structure and process indicators are adopted and integrated into the program's evaluation.**
3. **Quality measures and outcomes are reported to the organization-wide Quality Assurance/Performance Improvement program.**
4. **The pain management program and pain management protocols are regularly reviewed and revised based on identified opportunities for improvement and to meet best practice standards.**

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

1. Adult Pain Evaluation Resource Guide
   a. Numeric Scale
   b. Wong-Baker Face Scale
   c. Adult Non-Verbal Pain Scale (NVPS)
   d. Ventilated Patient Non-Verbal Pain Scale (NVPS)
   e. Proxy Pain Rating
   ~~e.~~f. Critical Care Pain Observation Tool (CPOT)
2. Pediatric Pain Evaluation Resource Guide
   a. Numeric Scale
   b. Wong-Baker Face Scale
   c. Behavioral Scales
      i. FLACC
      ii. Neonatal Pain, Agitation, and Sedation Scale (NPASS)
      iii. Neonatal Infant Pain Scale (NIPS)
3. Sedation Evaluation Resource Guide **(including Pain Assessment, Management and the Safe Use of Opioids)**

~~4. Patient's Rights Regarding Pain Control~~

~~5.~~**4.** Patient Care Services **Policy:** Communication with the Sensory Impaired and-or Persons with Language Barriers

~~6.~~**5.** Patient Care Services **Policy:** Interpretation and Translation Services

~~7.~~**6.** Patient Care Services Policy: Medication Administration

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

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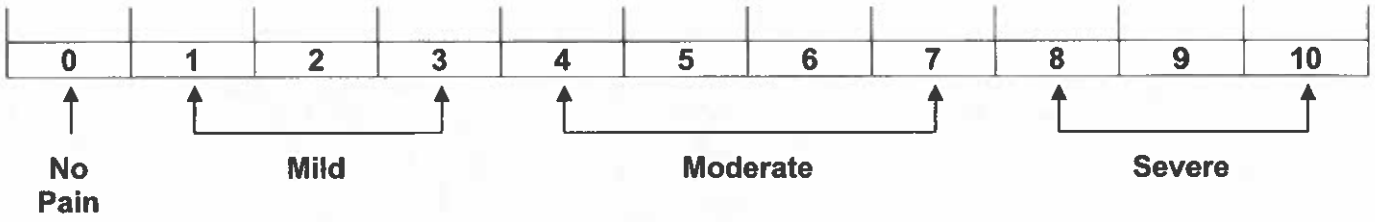
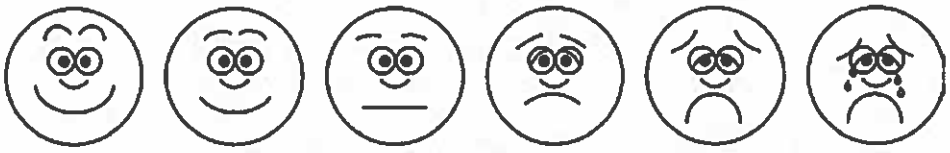
ADULT PAIN EVALUATION RESOURCE GUIDE

1. **NUMERIC SCALE (0 – 10):** For patients who can self-report



2. **WONG – BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. **ADULT NON-VERBAL PAIN SCALE (NVPS):** For patients who are unable to respond/determine the pain rating (0 – 10)

Subscales	0	1	2
FACE	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead.	Frequent grimace, tearing, frowning, wrinkled forehead.
ACTIVITY	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes.
GUARDING	Lying quietly, no positioning of hands over areas of body	Splinting areas of body, tense	Rigid, stiff
PHYSIOLOGIC I (Vital Signs)	Stable vital signs (no change in past 4 hours).	Change from baseline over past 4 hours in any of the following: SPB greater than 20mm HG HR greater than 20 beats/minute RR greater than 10 breaths/minute	Change from baseline over past 4 hours in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute RR greater than 20 breaths/minute
PHYSIOLOGIC II	Warm, dry skin	Dilated pupils, perspiring, flushing	Diaphoretic, pallor

4. ~~**VENTILATED PATIENT NON-VERBAL PAIN SCALE (NVPS):** For patients who are unable to respond/determine the pain rating (Best used in critical care areas) (0 – 10)~~

~~Subscales~~	~~0~~	~~1~~	~~2~~
~~**FACE**~~	~~No particular expression or smile.~~	~~Occasional grimace, tearing, frowning, wrinkled forehead.~~	~~Frequent grimace, tearing, frowning, wrinkled forehead.~~
~~**ACTIVITY**~~	~~Lying quietly, normal position~~	~~Seeking attention through movement or slow, cautious movement~~	~~Restless, excessive activity and/or withdrawal reflexes.~~
~~**GUARDING**~~	~~Lying quietly, no positioning of hands over areas of body~~	~~Splinting areas of body, tense~~	~~Rigid, stiff~~
~~**PHYSIOLOGY (Vital Signs)**~~	~~Stable vital signs~~	~~Change from baseline in any of the following: SPB greater than 20mm HG HR greater than 20 beats /minute~~	~~Change from baseline in any of the following: SPB greater than 30mm HG HR greater than 25 beats/minute~~
~~**RESPIRATORY**~~	~~Baseline RR/SpO2 Compliant with ventilator~~	~~RR greater than 10 above baseline, or 5% ↓SpO2 Mild asynchrony with ventilator~~	~~RR greater than20 above baseline, or 10% ↓SpO2 Severe asynchrony with ventilator~~

~~5.~~4. **PROXY PAIN RATING:** The family or caregiver thinks the patent is in pain.

Proxy Pain Rating:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

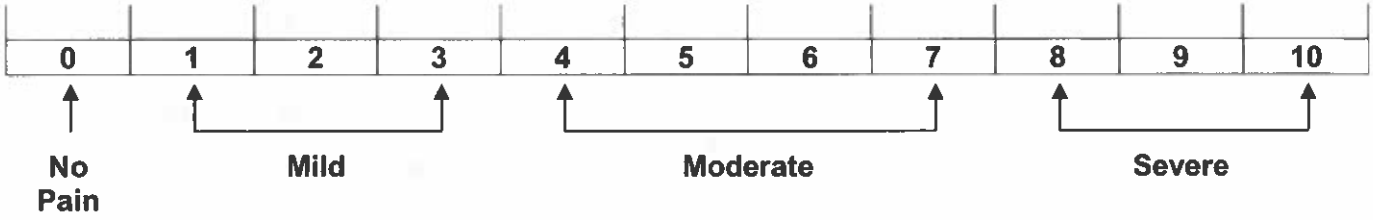
5. **CRITICAL CARE PAIN OBSERVATION TOOL (CPOT): Rates critically ill patients' pain based on clinical observation based on four domains – facial expressions, body movements, muscle tension, compliance with ventilation for intubated patients and vocalization for extubated patients. (0-8)**

Indicator	Description	Score	
Facial expression	No muscular tension observed	Relaxed, neutral	0
	Presence of frowning, brow lowering, orbit tightening, and levator contraction	Tense	1
	All of the above facial movements plus eyelid tightly closed	Grimacing	2
Body movements	Does not move at all	Absence of movements	0
	Slow, cauticous movements, touching or rubbing the pain site, seeking attention through movements	Protection	1
	Pulling tube, attempting to sit up, movin limbs/thrashing, not following commands, striking at staff, trying to climb out of bed	Restless	2

Muscle tension evaluation by passive flexion and extension of upper extremities	**No resistance to passive movement** **Resistance to passive movements** **Strong resistance to passive movements, inability to complete them**	**Relaxed** **Tense, rigid** **Very tense or rigid**	**0** **1** **2**
Compliance with the ventilator (intubated patients) **Or** **Vocalization (extubated patients)**	**Alarms not activated, easy ventilation** **Alarms stop spontaneously** **Asynchrony; blocking ventilation, alarms frequently activated** **Talking in normal tone or no sound** **Sighing, moaning** **Crying out, sobbing**	**Tolerating ventilator or movement** **Coughing but tolerating** **Fighting ventilator** **Talking in normal tone or no sound** **Sighing, moaning** **Crying out, sobbing**	**0** **1** **2** **0** **1** **2**

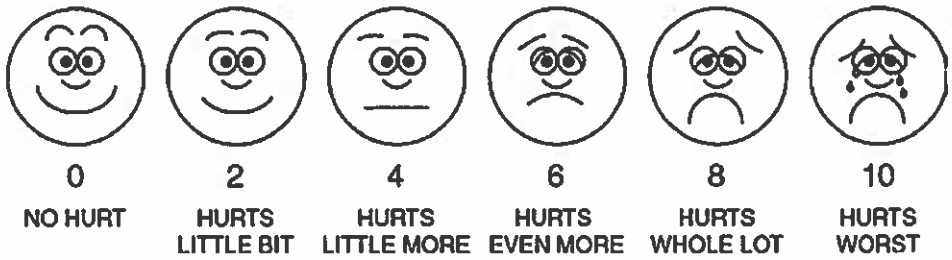
PEDIATRIC/NEONATAL PAIN EVALUATION RESOURCE GUIDE

1. **NUMERIC SCALE (0 – 10):** For patients who can self-report



2. **WONG- BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



3. **BEHAVIORAL SCALES:** For patients who cannot respond verbally

FLACC SCALE			
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown	Frequent to constant frown
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back & forth, tense	Arches, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steady, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by hugging touching, or "Talking to", distractible	Difficult to console or comfort

4. **NEONATAL PAIN, AGITATION, & SEDATION SCALE (NPASS)**

Criteria	Sedation		Normal	Pain/Agitation	
	-2	-1	0	1	2
Crying Irritability	No cry to painful stimuli	Briefly moans/cries to painful stimuli	Little crying Not irritable	Irritable/crying at intervals, consolable	Continuous high-pitched/ silent-cry. Inconsolable
Behavior State	No arousal to any stimuli, No spontaneous movement	Arouses minimally to stimuli. Little spontaneous movement	Appropriate for gestational age	Restless, squirming Awakens frequently	Arching, kicking. Constantly awake or arouses minimally to movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression to stimuli	Relaxed	Intermittent painful expression	Continual painful expression
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex. ↓ Muscle tone	Relaxed hands & feet Normal tone	Intermittent clenched toes, fists or finger splay, Body not tense	Continual clenched toes, fists or finger splay. Body is tense
Vital Signs HR, RR, BP SaO_2	No variability to stimuli, Hypo-ventilation/apnea	Less than 10% variability from baseline with stimuli	Baseline/normal for gestational age	↑ 10-20% from base-line Sao2 76-85% to stimulation – quick ↑	↑greater than 20% from baseline SaO_2 less than 75% to stimulation – slow ↑ Out of sync with vent

5. **Neonatal Infant Pain Scale (NIPS)**

Parameter	Finding	Points
Facial Expression	Relaxed	0
	Grimace	1
Cry	No Cry	0
	Whimper	1
	Vigorous Crying	2
Breathing Patterns	Relaxed	0
	Change In Breathing	1
Arms	Restrained	0
	Relaxed	0
	Flexed	1
	Extended	1
Legs	Restrained	0
	Relaxed	0
	Flexed	1
	Extended	1
State Of Arousal	Sleeping	0
	Awake	0
	Fussy	1

Sedation Evaluation Resource Guide

Pasero Opioid-induced Sedation Scale (POSS) with Interventions

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed

1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed

2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed

3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable;
Required Assessment:

- ☐ RN full respiratory assessment including: rate, rhythm, depth, auscultation including, patient taking deep breaths.
- ☐ Review past 12-18 hours pain flowsheet.
- ☐ Monitor respiratory status and sedation level closely until sedation level is stable <u>at less than 3</u> **and** respiratory status is satisfactory
- ☐ Initiate ETCO2 (required order TBD)

Critical Thinking	1. Notify provider requesting a decreased dose of opioid
	2. Administer a non-sedating, non-opioid such as acetaminophen or a NSAID, if ordered
	3. Increase stimulation such as: • Ask patient to take deep breaths every 5 – 10 min • Ambulate patient, sit patient up in chair, walk to bathroom

4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable;

- ☐ Stop opioid;
- ☐ Consider administering naloxone
- ☐ Stay with patient, stimulate, and support respiration as indicated by patient status;
- ☐ Call Rapid Response Team (Code Blue) if indicated; notify primary[2] or anesthesia provider;
- ☐ Monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

Ramsey Scale

Level of sedation for adults using the Ramsey Scale:

1 = Patient anxious and agitated or restless or both
2 = Patient cooperative, oriented and tranquil
3 = Patient responds to commands only
4 = A brisk response to loud auditory stimulus
5 = A sluggish response to loud auditory stimulus
6 = No response to loud auditory stimulus

Richmond Agitation Sedation Scale (RASS)

Points	Classification	Description
4	Combative	Overly combative or violent/ danger to staff
3	Very agitated	Pulls on or removes tube(s) or catheter(s) or has aggressive behavior toward staff
2	Agitated	Frequent nonpurposeful movement or patient- ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or violent
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained (more than 10 seconds) awakening, with eye contact to voice.
-2	Light sedation	Brief (less than 10 seconds) awakens with eye contact to voice
-3	Moderate sedation	Any movement to voice (no eye contact)
-4	Deep sedation	No response to voice, but movement to physical stimulants
-5	Unarousable	No response to voice or physical stimulation.

Tri-City Medical Center
Oceanside, California

Patient Safety Plan
~~2022~~-2023 - 2024

A. **PURPOSE**

1. The Patient Safety Plan is designed to:

a. Reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety by implementing standardized processes throughout the organization.

b. Implement~~ing~~ activities which contribute to the maintenance and improvement of patient safety.

2. The committee's 2023 – 2024 PS activities include but are not limited to the following:

a. Reduce falls with and without injuries by 50% by December 2022

b. Update the National Patient Safety Goals (NSPG) 2022 Net Learning Module and monitor staff compliance to the NSPGs

c. Provide education on Implicit Bias

d. Reinforcing the use of the Teach-Back method to assist with care transition

e. Identify patient safety projects that are potential risk and required Risk Management to conduct one of the following: Root Cause Analysis, Performance Improvement (PI), or Failure Mode and Effects Analysis (FEMA

~~2.~~3. Conduct a Culture of Safety Employee survey at annually

a. Support the mission, ~~and~~ vision**, and values** of Tri-City Medical Center (TCMC) as it pertains ~~to patient~~**to patient** safety, the work force and- visitor.~~,~~

i. Mission: to advance the health and wellness of the community we serve.

ii. Vision: be recognized as a healthcare system of choice in our community.

iii. Values: the needs of our patients come first:

1) Quality
2) Caring
3) Innovation
4) Safety
5) Integrity
~~1)~~6) Stewardship

B. **GUIDING PRINCIPLES**

1. The Patient Safety Plan e.g., the Plan is an overarching conceptual framework that guides the development of a program for patient safety initiatives~~,~~ and activities. It is operationalized through various activities in the realm of both patient safety and patient safety risk.
2. The plan supports TCMC philosophy that patient safety and risk management are everyone's responsibilities. Teamwork and participation among management, providers, employees, and volunteers is essential for an efficient and effective risk management and patient safety program.
3. The Plan is implemented through the coordination of activities in multiple departments. 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

Patient Care Service Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/22	05/22, **10/23**	06/22, **12/23**	n/a	06/22

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. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions may be taken.

4. The Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risk to patient safety, and chosen loss prevention and reduction strategies. These principles ~~provides~~**provide** the foundation for developing and updating key policies and procedures for day-to-day ~~risk management~~ activities, including the following:
   a. Reporting and management of adverse events and near misses
   b. Staff education as it pertains to patient safety matters

C. GOVERING BODY LEADERSHIP

1. The governing Board authorizes the formal program and adoption of this plan through a resolution documented in the Board meeting minutes.
2. The governing Board is committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in organization operations.
3. The governing body empowers the organization's leadership and management teams with the responsibility for implementing risk management and patient safety strategies by their leadership, commitment and support.

D. DEFINITIONS

1. Adverse Event or Incident: An undesired outcome or occurrence not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services. The outcome may or may not be a patient safety incident.
2. Culture of Safety: The collective product of individual and group values, attitudes, competencies, and patterns of behavior in safety performance. It is an environment that regards safety as its primary goal through promotion of teamwork, effective communication, and the implementation of modern safety concepts. A culture of safety is concerned with preventing errors, accidents, and adverse events. ~~This is accomplished by way of an environment that promotes open and honest communication.~~
3. Healthcare Associated Harm: Harm arising from or associated with plans or actions taken during the provision of health care rather than an underlying disease or injury. ~~Also known as iatrogenic.~~
4. Just Culture: An organizational paradigm that emphasizes evidence-based best practices, learning from error analysis, and providing constructive feedback, rather than blame and punishment.
5. National Patient Safety Goals (NPSGs): Annual list published by The Joint Commission (TJC). The purpose of the NPSGs is to improve patient safety by focusing on problems widely identified in healthcare and ways to mitigate or solve them. ~~Identified goals include but are not limited to accurate patient identification, hand-off communication, and medication safety, decreasing clinical alarm fatigue, Universal Precautions, and infection prevention~~.
6. Patient Safety Evaluation System: The collection, management, and analysis of patient safety information.
7. Patient Safety Event: An event that negatively impacts a patient including patient safety incidents and near misses.
8. Patient Safety Incident: A patient safety event that reaches a patient and resulted either in no harm (no harm incident) or harm (harm incident). ~~The concept "reaches a patient" encompasses any action by a workforce member or environmental circumstances that exposes a patient to harm.~~
9. Preventive Measure: Process designed, or course of action taken, to keep something possible or probable from happening or existing; i.e., to prevent a patient safety event

10. Sentinel Event: ~~Defined by the Joint Commission as~~ an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.
11. Time of Discovery: Date/time when a patient safety concern was discovered.
12. Time of Occurrence: Date/time when a patient safety event occurred or began if it occurred over a period of time.
13. Unsafe and/or Hazardous Condition: Any set of circumstances, exclusive of a patient's own disease process, that significantly increases the likelihood of a serious adverse outcome or loss for a patient due to an accident or injury to a visitor, workforce member, volunteer, or other individual. ~~These are reported in our on-line incident reporting system~~.

E. SCOPE AND FUNCTIONS

1. The Patient Safety Plan in collaboration with the Risk Management Program interfaces with many operational and clinical departments and services throughout the organization. These operational and clinical departments include, but are not limited to the following:
   a. Administration and Senior Management
   b. Ancillary Services
   c. Buildings and Grounds
   d. Disaster Preparation and Management
   e. Education Department / Staff Education
   f. Employee Health Services
   g. Event/Incident/Accident Reporting and Investigation
   h. Infection Control
   i. Information Technology
   j. Marketing/Advertising/Public Relations
   k. Medical Records
   l. Nursing Administration
   m. Nursing Services
   n. Pharmaceuticals and Therapeutics
   o. Product/Materials Management
   p. Pulmonary Department
   q. Quality/Performance Improvement
   r. Regulatory Compliance
   s. Safety and Security

F. PATIENT SAFETY (PS) PROGRAM

1. Patient Safety (PS) plan is administered through by the Patient Safety Officer or alternate as designated by the Chief **Nurse Executive (CNE)** ~~of Patient Care Services and/or Director Clinical Quality Resources~~ with the support of the Leadership and the Patient Safety Committee
2. Goals and Objectives
   a. The PS plan goals and objectives are as follows:
      i. Encourage organizational learning about medical and health care errors
      ii. Incorporate recognition of patient safety as an integral job responsibility
      iii. Provide education on patient safety in job specific competencies
      iv. Encourage recognition and reporting of medical and health care errors without judgment or blame
      v. Involve patients in decisions about their health care
      vi. Report investigative findings internally including actions taken to refine and optimize systems and processes related to patient safety
      vii. Collaborate with Risk Management, Nurse Managers and TCMC clinical and non-clinical staff to promote a Just Culture
      viii. Pursue opportunities to improve the quality of patient care, services, and safety
3. Patient Safety Committee
   a. The PS committee will be chaired by the Patient Safety Officer or designee

b. The Patient Safety Officer (PSO) will be the Manager of Regulatory Compliance **and Accreditation** or designee identified by **CNE.**~~the Director Clinical Quality Resources.~~ The PSO reports to the C**NE**~~hief Nurse Executive~~ or designee.

c. The responsibilities of the P**SO**~~atient Safety Officer~~ include but are not limited to compliance with patient safety standards and initiatives, evaluation of work performance as it relates to patient safety, reinforcement of the expectations of the PS plan and reporting patient safety measures and activities to the Quality Assessment and Performance Improvement (QAPI) Committee
   i. The PS Committee is an interdisciplinary group that manages the Patient Safety Program through a systematic, coordinated, continuous approach
   ii. The PS Committee membership includes a medical staff representative and services involved in patient care i.e., Pharmacy, Laboratory, Surgical Services, Risk Management, Infection Control, Radiology, Rehabilitation Services, and Nursing and non-clinical services and departments
   iii. The team shall meet at least quarterly to assure the maintenance and improvement of patient safety in establishment of plans, processes and mechanisms identified in the Centers for Medicare and Medicaid (CMS) Conditions of Participation provisions and The Joint Commission (TJC) PS standards

d. Scope and Functions
   i. The scope of the PS committee includes the sharing of knowledge and practices across multiple disciplines to optimize the use of findings from internal reports e.g., incident reporting, quality measures, risk management, and committee discussions.
   ii. The committee will review and analyze external resources e.g., Sentinel Events, California Department of Public Health All Facilities Letters (AFLs), and nationally recognized patient safety organizations
   iii. The committee will make recommendations to reduce the overall prospect of adverse events based on evidence-based and best practices to improve patient safety
   iv. As an integral part of a patient safety and quality improvement the ~~following~~ PS measures ~~-~~will ~~be a~~ focus of the **following** ~~2022 PS~~ activities:
      1) Medication Safety, Adverse Drug Events/Reactions, Medication Errors, Use of Opioids
      2) Documentation **in the medical record**
      3) Blood Transfusion ~~A~~**a**dministration and reactions
      4) Patient Flow (throughput)
      5) Pain Management & Assessment Documentation when Opioids are used
      ~~6) Code Blue/Resuscitation Staff Debriefings~~
      ~~7~~**6)** Nursing Quality Indicators
         a) Pressure Injuries
         b) Falls
         c) Restraint use and documentation of discontinue use
      ~~8~~**7)** Moderate Sedation Outcome monitoring
      8) Critical Results of Test Timeliness
      9) Staff and patient communication
      ~~9~~**10) Conduct a Patient Safety Survey**
   v. The committee's **FY 2024**~~2022 – 2023~~**4** PS activities include but are not limited to the following:
      1) Reduce falls with and without injuries by 50% **based on the previous year reported data** ~~by December 2022~~
      2) Update the National Patient Safety Goals (NSPG) **annual** ~~2022~~ Net Learning Module and monitor staff compliance to the NSPGs
      3) ~~Provide education on Implicit Bias~~

4) Reinforcing the use of the Teach-Back method to assist with care transition

~~4~~**5)** **Reintroduction of AIDET communication process {AIDET = Acknowledge, Introduce, Duration, Explanation and Thank your}**

~~5~~**6)** Identify patient safety projects that are ~~potential risk~~**potential risk** and required **for** Risk Management to conduct one of the following: Root Cause Analysis, Performance Improvement (PI), or Failure Mode and Effects Analysis (FEMA)

~~6~~**7)** Conduct a Culture of Safety Employee survey at annually

vi. **The time frame for completion of PS activities will be determined by the PS committee. Data for improvement will be reported to the PS Committee as scheduled by the PS reporting schedule.**

~~The signatures below represent an acceptance of the Patient Safety Plan.~~

~~_____ Date Approved: _____~~
~~Steve Dietlin, Chief Executive Officer~~
~~Tri-City Health Care District~~

~~_____ Date Approved: _____~~
~~Candice Parras,~~
~~Chief Nurse Executive~~

~~_____ Date Approved: _____~~
~~Gene Ma, Chief Medical Officer~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ~~PNEUMOCOCCAL AND~~ INFLUENZA VACCINE SCREENING AND ADMINISTRATION

I. **POLICY:**

A. Function:

1. To provide guidelines to the Registered Nurse (RN) when administering ~~Pneumococcal and/or~~ Influenza Vaccine(s) to the appropriate patient(s) as indicated per criteria set forth by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
2. To provide guidelines when a physician does not want the patient to receive the vaccine(s).

~~B. Circumstances for Pneumococcal Vaccine:~~

~~1. Setting: Tri-City Medical Center~~
~~2. Supervision: None required~~
~~3. Exclusions: Immunization in the laboring patient and women currently pregnant will be according to physician orders and not this standardized procedure.~~
~~4. Patient indications:~~
~~a. Pneumococcal Vaccine Risk Assessment for all patients 65 years and older.~~
~~b. Prevnar 13 should be given to patients age 65 and older who have never received Prevnar 13, Pneumovax 23, or have unknown vaccination history.~~
~~c. If the patient does not meet criteria above, do not immunize.~~
~~5. The Pneumococcal Vaccine should NOT be routinely given without a physician's order if the patient:~~
~~a. Has a contraindication:~~
~~i. Had a previous reaction to the Pneumococcal vaccine.~~
~~ii. Received a bone marrow transplant within the past 6 months.~~
~~iii. Has received chemotherapy or radiation within the last 2 weeks.~~
~~iv. Has received the shingles vaccine (Zostavax) within the last 4 weeks.~~
~~b. Ordered not to have vaccine by physician.~~
~~c. Refuses or advocate refuses.~~
~~6. If no exclusion criteria identified, then immunize.~~

~~C.~~**B.** Circumstances for Influenza Vaccine:

1. Setting: Tri-City Medical Center
2. Supervision: None required
~~3. Exclusions: Immunization in the laboring patient will be according to physician orders and not this standardized procedure.~~
~~4.~~**3.** Patient indications:
   a. Influenza Vaccine Risk Assessment for all patients 6 months of age and older.
   b. The Influenza Vaccine should be given to patients admitted and/or discharged during the normal flu season **(October through March)** until the vaccine is no longer available, if any of the following indications are met:
      i. Age 6 months and older.
      ii. Women who will be pregnant during the influenza season ~~(October through March)~~ NOTE: Influenza vaccine is not contraindicated at any stage of pregnancy.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Pharmacy & Therapeutics Committee	Infection Control Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/06, 1/15, 03/18, **08/22**	12/11, 02/15, 06/15, 01//16, 04/18, **08/22**	12/1, 07/15, 01/16, 04/18, **09/22**	1/12, 07/15, 01/16, 05/18, **10/22**	07/15, 03/16, 10/18, **11/22, 04/23**	01/12, 09/15, 07/16, 10/18, **10/23**	02/12, 09/15, 09/16, 11/18 **10/23**	01/19, **12/23**	10/15, 10/16, *n/a*	02/12; 10/15, 11/16, 01/19

iii. Women who are knowingly pregnant shall receive single-dose preservative free* vaccine (*Not to exceed 1mcg of Thimerosal per 0.5mL dose).
1) Pharmacy to provide single-dose syringe/vial for knowingly pregnant women if available.
iv. Influenza immunization history is unknown by patient or advocate.

~~5.~~**4.** The Influenza Vaccine should NOT be given if the patient:
a. Has contraindication
i. Has allergy to eggs or reaction to prior influenza vaccine (i.e., anaphylactic allergic reaction).
ii. Had diagnosis of Guillian-Barre Syndrome within six (6) weeks of vaccination (will be left up to the individual healthcare provider to decide if recommended).
iii. Received bone marrow transplant within past six (6) months.
iv. Had a previous influenza immunization this flu season.
b. Ordered not to have vaccine by physician.
c. Refuses or advocate refuses.

~~6.~~**5.** If no exclusion criteria identified, then immunize.

II. PROCEDURE:

A. During the initial assessment, the RN will complete ~~the Pneumococcal /~~Influenza Vaccination Adult Immunization Assessment Screen in Cerner to determine whether or not the vaccinations are indicated according to the following criteria:
1. If the patient meets any inclusion criteria and no exclusion criteria, the RN will inform the patient/advocate that they are eligible for the vaccination~~(s)~~, give the patient/advocate the vaccination information sheet~~(s)~~, and plan to administer the vaccination~~(s)~~.
2. If the RN is unsure of whether the patient is a candidate for the vaccine~~(s)~~, the physician should be contacted for specific orders.

B. Unless the physician has signed an order to withhold the ~~Pneumococcal and/or~~ Influenza vaccine, remove the age appropriate dose assigned by pharmacy from the **automated dispensing machine**~~Pyxis Medication station~~ and administer the vaccine(s).

C. For patients in the Emergency Department, the ~~Pneumococcal and/or~~ Influenza vaccine should be administered at the time the physician order is received.

III. DOCUMENTATION:

A. Document the vaccine administration in the medical record.
B. Document vaccine lot number and site of administration.
C. Document that the Vaccination Information Sheet was given to the patient.
D. Document refusal of immunizations.
E. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record.
1. Not required if a screening process triggers the order.

IV. PATIENT EDUCATION:

A. If the patient meets inclusion criteria, the RN will review the ~~Pneumococcal and~~ Influenza Vaccine Information sheet~~(s)~~ with the patient and give the patient a copy.

B. For transfers to skilled nursing facilities and other hospitals, print and send a copy of the Immunization Tab indicating vaccine~~(s)~~ administered, with a copy of the Medical Record.

V. REQUIREMENTS FOR R.N. INITIATING STANDARDIZED PROCEDURE:

A. Current unencumbered California RN license
B. Initial evaluation: Orientation
C. Ongoing evaluation: Annually

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

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every 2 years or review procedure per Hospital policy.

VII. **CLINICIANS AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:**

A. All RNs who have successfully completed requirements as outlined above are authorized to direct and perform Administration of ~~Pneumococcal and/or~~ Influenza Vaccine.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PROFEND

I. **POLICY:**

A. Function: **To describe the purpose and administration of Profend**

1. **Nasal decolonization swab to help reduce infection in surgical and critical care patients**~~Antiseptic for preparation of skin~~

~~2. Helps reduce bacteria that can potentially cause skin infection, such as *Staphylococcus aureus*~~

B. Circumstances: **Prevent the colonization of Staphylococcus aureus**

1. Setting: **For use on surgical and critical care patients**

~~1.~~**2. Supervision: none required**

II. **PROCEDURE:**

A. Profend will be applied twice daily to the nares for a total of 5 days for the following patients within 24 hours of admission:

1. Patients directly admitted to the Intensive Care Unit (ICU)
   a. This includes patients transferred into ICU from other medical units

B. Profend will be applied once ~~peri~~**pre-**operatively for all surgery patients

C. **Collect all ordered nasal swab specimens prior to Profend application**~~For patients who are scheduled for a MRSA nasal swab, start Profend after MRSA nasal swab~~**.**

D. The nurse shall perform the following steps for nasal application:

1. ~~Step 1:~~ Use tissue to clean inside of both nostrils, including inside tips of nostrils. Discard tissue. Using four swabsticks, perform Steps 2-6 two times for right nostril and two times for left nostril.
2. ~~Step 2:~~ Hold applicator tube between thumb and forefinger at blue band with tube in vertical position with tip/handle up. With the other hand, place thumb and forefinger at base of handle ("thumb-to-thumb").
3. ~~Step 3:~~ Bend and snap open along break line.
4. ~~Step 4:~~ Bend and snap in opposite direction to disconnect swabstick.
5. ~~Step 5:~~ Remove swabstick from tube. Discard tube.
6. ~~Step 6:~~ Insert swabstick comfortably into one nostril. For a total of 15 seconds, rotate swabstick around circumference of nostril and then rotate in the anterior nares for a minimum of 6 complete revolutions with slight pressure, covering all surfaces. Discard swabstick.
7. Note: Do not blow nose. If solution drips, gently wipe with a tissue

E. Exclusion Criteria:

1. Individuals who are allergic or sensitive to iodine
2. Not for use in eyes or mouth or over large areas of the body

F. Transfer and discharges

1. For patients who are transferred or discharged prior to completion of the ~~5 day~~**5-day** course, Profend will be discontinued

III. **DOCUMENTATION:**

~~1.~~**A. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the order into the electronic health record.**

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board o Director
NEW 01/23	01/23	02/23	04/23	05/23	07/23	10/23	12/23	n/a	

~~III.~~IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current **unencumbered** California **Registered Nurse** license.
B. ~~Education:~~
C. Initial Evaluation: **Orientation**
D. Ongoing Evaluation: **Annual**

~~IV.~~V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

~~V.~~VI. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All **Registered Nurses**~~healthcare providers~~ in **the Intensive Care Unit, Surgical Services and Labor and Delivery** who have successfully completed requirements as outlined above are authorized to direct and perform **the Profend** Standardized Procedure.

~~VI.~~VII. REFERENCE(S):

A. PDI in vivo Study PDI-0113-CTEV01.
B. PDI manufacturer instructions for use.
C. PDI Study PDI-0113-KT1.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: REGISTERED NURSE (RN)-MANAGED URINARY CATHETER REMOVAL

I. **POLICY:**

A. Function: Management of the adult patient with indwelling urinary catheter

~~A.~~**B. Supervision: none required**

~~B.~~**C. Contraindications for**~~Patients with urinary catheters with any of the following should NOT be~~ RN-managed **urinary catheter removal**:

1. Specific provider order not to remove catheter
2. Difficult catheter insertion
3. Urologic, gynecological or peri-rectal/anal surgery
4. Continuous bladder irrigation
5. Chronic indwelling catheter (e.g. placed prior to admission)
6. Suprapubic catheter or nephrostomy tube present
7. New or acute spinal cord injury, neurosurgery patients

II. **INSTRUCTIONS:**

A. Assess patient **each shift**~~daily~~ for valid indications to continue urinary catheter:

1. Acute urinary retention
2. Bladder outlet obstruction and neurogenic bladder
3. Output monitoring in critical patient
4. Urologic/gynecological procedures
5. Sacral/perineal wound with incontinence
6. Prolonged immobilization (e.g. unstable spine/pelvic/hip fracture, trauma)
7. Comfort Care/end-of-life care

B. Assess patient for external catheter use:

1. Patient requiring urine output monitoring but does not meet indications for indwelling urinary catheterization
2. Urinary incontinence and/or frequent urination
3. Difficulty walking from bed or chair to toilet
4. Difficulty using a urinal or bedpan
5. Post-surgical or procedure immobility
6. Skin injury or irritation related to urinary incontinence or diapers
7. Bedrest orders

C. No urinalysis (U/A) or culture required upon removal.

III. **CATHETER REMOVAL:**

A. Remove catheter if patient does not **have**~~meet~~ any of the **contra**indications ~~in Section IIA~~.

1. Document date/time removed in the medical record
2. Monitor **intake and output** (I&O) per the Standards of Care Adult
3. Use external catheter if indicated
4. Catheter removal should be performed ~~between 0600 and 1000~~ to allow a sufficient period of observation **(recommend removal in morning)**.

IV. **BLADDER MANAGEMENT (refer to algorithm below)**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
NEW 11/21	12/21	03/22	04/22, ~~11/22~~04/23	n/a	07/23	10/23	12/23	n/a	

A. Patient voids within 6 hours and no symptoms – per the Standards of Care Adult
   1. Observe and monitor I&O ~~or~~
B. Patient is uncomfortable, incontinent or voids less than 200 mL within 6 hours after removal:
   1. Perform bladder scan
      a. If bladder volume is less than 300 mL, observe, provide ongoing toileting and reevaluate in 2-3 hours (earlier if symptomatic) – may repeat process times 3
         i. If voided but post void residual (PVR) is less than or equal to 150 mL – reevaluate in 2-3 hours. If PVR is less than 150 mL x 2, no further scanning required unless inability to void returns.
      b. If bladder volume is greater than or equal to 300 mL, perform straight cath for urine residual and reevaluate in 2-3 hours – may repeat process x 3
         i. If patient requires straight catheterization x3 AND next bladder scan volume greater than or equal to 300 mL obtain order from physician to insert **urinary**~~foley~~ catheter

V. DOCUMENTATION:

A. Document the following in the medical record:
   1. ~~Daily c~~**C**atheter assessment
   2. Urinary catheter removal date/time
   3. PVR amounts in medical record

VI. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current unencumbered California RN license.
B. Education and Training: Urinary catheter insertion, maintenance, and removal training including how to use a bladder scanner.
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annual~~ly urinary catheter management review.~~
~~E. Advanced Care Techinicians (ACT) may remove urinary catheter as directed by an RN.~~

VII. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform RN-Managed Urinary Catheter Removal Standardized Procedure.

VIII. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

IX. REFERENCE(S):

A. Center for Disease Control and Prevention (2009). Guideline for Prevention of Catheter-Associated Urinary Tract Infections
B. Lo, E., Nicolle, L., Classen, D., Arias, K. M., Podgorny, K., Anderson, D. J., Yokoe, D. S., & et al (2008). Strategies to prevent catheter-associated urinary tract infections in acute care hospitals. Infection Control and Hospital Epidemiology, 29, S41-S50
C. Elsevier Performance Manual Clinical Skills (2021). Urinary Catheter Indwelling (Foley) Catheter Removal.
D. Agency for Healthcare Research & Quality (AHRQ). (2020). Toolkit for Reducing Catheter-associated Urinary Tract Infections in Hospitals. Retrieved from www.ahrq.gov

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**06/14**	**SUBJECT:**	**Transport/Transfer of Patients Within the Facility**
REVISION DATE~~(S)~~:	**06/14, 11/18**		

Patient Care Services Content Expert Approval:	**~~07/17~~11/~~21~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~05/18~~10/22**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~07/18~~11/22**
Department of Anesthesiology Approval:	**~~09/18~~10/23**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/18~~10/23**
Administration Approval:	**~~10/18~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/18**

A. **PURPOSE:**

1. To ensure safe and appropriate patient transport/transfer within the facility.

B. **POLICY:**

1. Patient safety, infection control, and requests shall be considered in all transfer decisions.
2. Nursing staff, in collaboration with the **Nurse Leader/Charge Nurse** ~~Assistant Nurse Manager (ANM)~~/Administrative Supervisor (AS), may transfer patients based on infection control indications; bed placement needs, and per family/patient request as beds permit.
3. The patient shall always be attended during transport or transfer.
4. Patients on 5150 or on voluntary hold must be accompanied by staff member **and not left unattended.**~~.~~
5. Patient movement assistive devices and/or the number of staff members assisting should be adequate to provide for the patient and staff safety during transport or transfer activities.
   a. Staff shall wait for adequate number(s) of staff and/or devices, to safely transfer or move a patient to prevent injury to self or others. Refer to Patient Care Services (PCS) Policy: ~~Lift Team~~ **Patient Mobility Technician** for additional information.
   b. Proper body mechanics shall be used when transferring (moving) or transporting a patient.
6. Safety measures to be implemented during patient transport or transfer include, but are not limited to:
   a. Locking wheels and stabilizing transport vehicles or patient beds during transfer activities.
   b. Elevating side rails.
   c. Hanging and securing intravenous (IV) containers away from patient's head.
   d. Protecting patient's head, arms and legs.
   e. Ensuring that transport staff remains at the head of the transport vehicle.
   f. Pushing patient's feet first and avoiding rapid movements, especially during turns; except when being placed on an elevator, the patients shall be placed in the elevator headfirst.
      i. Excludes justice involved patients, see PCS Policy: Justice Involved Patients
   g. Maintaining the integrity and function of IVs, catheters, tubes, drainage systems and monitoring equipment.
   h. Obtaining assistance and specific instructions for the transport/transfer of patients with special needs.

7. Hand-off communication shall be performed before and after transport/transfer per Patient Care Services Policy: Hand-Off Communication.
8. When a patient is transferred from their primary location to another department:
   a. The **receiving**~~primary~~ department will document the date/time patient **arrives**~~leaves the department~~ and **new** location patient is transferred to in the electronic health record (EHR).
   b. The hard copy of the patient's chart will be sent with the patient, if applicable.
9. When the patient returns to the primary department, the date and time will be documented.
10. ~~If the patient is assigned a~~ **The** primary nurse:
    a. The primary nurse will provide a safety hand-off to transporter if the patient is transferred unaccompanied by **a RN** ~~a licensed~~ nurse.
    b. Assess the patient on return to unit and document any changes in the patient's status in the EHR.
11. Telemetry and Acute Care Services (ACS) Monitored units nursing staff shall notify the Monitor Technician (MT) by telephone or the monitor system off unit function per the PCS Policy: Monitor Technicians (MTs): Communication Process.

C. **CHANGE IN LEVEL OF CARE PROCESS:**

1. Transferring unit obtains physician order for transfer.
   a. The Registered Nurse (RN) requests for the physician/Allied Health Professional (AHP) to complete transfer orders and reconcile the medications.
   b. Patients may be transferred internally based on assessment findings, physician orders, acuity changes, infection control needs, or safety.
   c. Patients going to Acute Rehab ~~or Behavioral Health Unit (BHU)~~ must be discharged from the inpatient encounter and admitted to Acute Rehab ~~or BHU~~ as a new encounter facilitated by Registration.
   d. ~~BHU patients may be transferred to Emergency Department (ED) for medical evaluation to meet inpatient admission criteria.~~
      i. ~~If patients are admitted to an inpatient unit, they must be discharged from BHU and readmitted.~~
   e. Inpatients that require emergent evaluation and intervention may be transferred to the ED for medical care.
2. Transferring unit notifies ~~ANM/~~AS of transfer order and inputs requests to the bed board tracking system.
3. **The nurse leader or charge nurse** ~~ANM/~~AS notifies transferring unit of new patient room assignment via the bed tracking system.
4. Transferring unit ensures all physician orders are current and appropriate and all medications reconciled for non-urgent transfers.
   a. ~~When patients are transferred from the Intensive Care Unit (ICU), all orders for diagnostic tests shall be assessed for continued appropriateness by the physician/AHP either with the transfer order or within 24 hours of transfer.~~
5. Accepting unit ensures all physician orders are reconciled for urgent transfers.
6. The transferring unit completes the transfer transaction on the computer, ensuring correct and accurate accommodation, and service codes.
   a. Patients going to Acute Rehab ~~or BHU~~ must be discharged from the inpatient encounter and admitted to Acute Rehab ~~or BHU~~ as a new encounter facilitated by Registration.

D. **REGISTERED NURSE RESPONSIBILITIES:**

1. Provide hand-off communication to receiving unit and/or transporter per Patient Care Services Policy: Hand-Off Communication
2. Evaluate patient condition prior to departure and arrival to the unit.
3. Empty urinary drainage bag prior to transport.
4. Ensure adequate IV solutions for transport.
5. Ensure patients on a cardiac monitor are transported/transferred on a cardiac monitor with;

a. An RN competent in EKG recognition.
   i. Patients currently on a cardiac monitor may be transported without monitor based on the order of the physician.
   ~~i.~~**ii. Medically monitored patients from the Emergency Department to 4P may be transported without a cardiac monitor.**
b. A resuscitation bag/mask, oxygen (sufficient amount to transfer) and oral airway

6. If patient is pre-medicated for diagnostic test, such as Magnetic Resonance Imaging (MRI), with a benzodiazepine and/or a narcotic within one hour of leaving the floor, a nurse must accompany the patient during transport. The patient must be monitored with a continuous pulse oximetry device, at the minimum, during transport and while off the unit. A nurse should be available at all times to observe the patient for change in condition.
   a. Vitals signs will be obtained based on the clinical condition of the patient or upon change in condition.
7. If transferring to another inpatient unit the transferring nurse shall:
   a. Explain the rationale of the transfer to patient
   ~~a.~~**b. Ensure the** ~~and assist with notification of~~ patient's spouse/family/significant other **are notified of the transfer e.g., room number, transferring unit telephone number**.
   ~~b.~~**c.** Send all patient related items and/or equipment with patient and label all personal items including intravenous piggybacks (IVPBs), IVs, and patient-specific medications.

E. **TRANSPORTER RESPONSIBILITIES**:
1. Receive hand-off per Patient Care Services Policy: Hand-Off Communication.
2. Transporting or transferring a patient from a nursing unit, the transporter shall:
   a. Identify the patient to be transported/transferred.
   b. Notify the primary nurse that the patient will be leaving the nursing unit.
   c. Cardiac or Medically monitored patients notify MT per the PCS Policy: Monitor Technicians (MTs): Communication Process
   d. Prepare patient for transport or transfer.
   e. If transferring to another inpatient unit, ensure belongings and valuables accompany the patient.
3. Transporting/transferring a patient to a nursing unit the transporter shall:
   a. Notify the primary nurse/relief RN or advanced care technician (ACT) patient has arrived/returned to the nursing unit.
   b. Ensure the following:
      i. Patient is repositioned safely in bed.
      ii. Bed wheels are locked.
      iii. Bed in placed in the low position.
      iv. Call button and television remote are within patient's reach.
      v. Bedside table is within patient's reach.
   c. Cardiac or Medically monitored patients notify MT per the PCS Policy: Monitor Technicians (MTs): Communication Process
4. Notify the receiving unit's nurse, assist patient to room, and provide a safety hand-off to the receiving nurse.

F. **RELATED DOCUMENT(S):**
1. NICU Policy: Transfer of Neonates and Infants
2. Patient Care Services Policy: Chemotherapy Patient Intake to the Nursing Units (Direct Admit, Outpatient or Forensic) Procedure
3. Patient Care Services Policy: Hand-Off Communication
4. Patient Care Services Policy: Lift Team
5. Patient Care Services Policy: Monitor Technicians (MTs): Communication Process
6. Women and Newborn Services Policy: Infant Transport- Intrafacility
~~6.~~**7. 42 Code of Federal Regulation – Conditions of Participation for Hospitals, 9.2022.**

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE:	**10/93**	**SUBJECT:**	**Contraindications to Cardiac Rehab Exercise**
REVISION DATE:	**6/97, 6/03, 12/05, 11/07, 01/13, 08/20**		

Cardiac Rehabilitation Approval:	**~~02/20~~09/23**
Division of Cardiology Approval:	**~~07/20~~10/23**
Medical Executive Committee Approval:	**~~07/20~~10/23**
Administrative Approval:	**~~08/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
1. To establish contraindications to cardiac rehabilitation exercise.

B. **POLICY:**
1. Patients with one or more of these contraindications shall not be allowed to exercise.

C. **DEFINITIONS:**
1. Contraindications to exercise:
   a. Unstable angina
   b. Resting diastolic blood pressure of greater than ~~110~~**100**mm Hg or systolic BP greater than ~~210~~**170 mmHg** shall be evaluated on a case by case basis
   c. Orthostatic blood pressure drop of greater than 20 mm Hg with symptoms
   d. Acute systemic illness or fever
   e. Uncontrolled atrial or ventricular arrhythmias
   f. Uncontrolled sinus tachycardia (greater than 120 beats per minute)
   g. Uncompensated congestive heart failure
   h. Glucose level **less than 100mg/dL or** greater than 300**mg/dL** unless cleared by physician (participants primary MD or Cardiac Wellness Medical Director and/or supervising physician)

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Exercise Prescription**

REVISION DATE: 12/05, 10/07, 01/08, 01/13, 08/20

Cardiac Rehabilitation Approval:	**~~02/20~~09/23**
Division of Cardiology Approval:	**~~07/20~~10/23**
Medical Executive Committee Approval:	**~~07/20~~10/23**
Administrative Approval:	**~~08/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To establish guidelines for prescribing maximal safe exercise for cardiovascular patients.
2. To establish guidelines for exercise prescriptions that enhances cardiopulmonary endurance, body composition, flexibility, muscular strength and muscular endurance.

B. **POLICY:**

1. The exercise prescription **is developed during the intake session which includes baseline exercise evaluation, review of comorbidities, and patient goals.** ~~The exercise prescription signed by the MD~~ shall allow a patient to begin program at a low level of intensity, increasing to reach target heart rate (THR) or other specified parameters set by patient's physician. The **frequency,** intensity, duration, and type of exercise to be performed shall be determined by the cardiac rehabilitation staff. The cardiac rehabilitation staff shall be responsible for development of the exercise prescription, which **is included as part of the daily session report generated after each session and signed by the supervising physician.** ~~shall bear the appropriate signature.~~ The Cardiac Rehabilitation Registered Nurse, Exercise Physiologist, and/or **E**exercise **T**technician is to increase or progress the intensity or workload in order to meet target heart rate. Exercise prescription for Phases II and IV of Cardiac Rehabilitation Programs shall be developed in accordance with the patient's health history and clinical status.

C. **GENERAL GUIDELINES:**

1. Intensity of exercise shall be prescribed not to exceed 85% of the maximal predicted heart rate. Intensity of exercise may be prescribed by heart rate, rating of perceived exertion (RPE) or by METS. The target heart **rate** is calculated by calculating 60-80% of maximum heart rate, using the physician approved age-related chart for maximum heart rate.
2. The Rating of Perceived Exertion (RPE) Scale may be used as a valid and reliable indicator of the level of physical exertion during constant intensity exercise to establish exercise prescription intensity.
   a. Patients shall self-monitor the RPE at a specified heart rate until the heart rate – RPE relationship is learned. Then the RPE may be employed as an additional method for regulating intensity.
   b. The intensity of exercise may be prescribed by determining 70% of the patient's maximum predicted heart rate and then selecting activities with energy expenditure in METS at the desired level.
3. Duration of the conditioning phase shall be 30-60 minutes and the patient shall report no undue fatigue an hour after exercise completion.
4. The frequency of exercise sessions shall be 3 times weekly.

5. Progression in the outpatient exercise program is dependent on the patient's functional capacity, clinical status and needs or goals. The heart rate, signs and symptoms**, and RPE** are indicators for progression to higher metabolic workloads.
6. The type of exercise performed may include aerobic activities such as walking/running, bicycle ergometer, rowing machine, **upright bike,** recumbent bicycle, recumbent stepper, **recumbent elliptical,** elliptical cross-trainer, arm ergometer, and free weight workouts.
7. With supervising physician approval, patients can participate in the group strength training classes. Light weights (1 pound each arm up to 10 pounds each arm) with repetitions may be employed to increase muscle strength and endurance.
~~6.~~**8.** Patients with uncontrolled hypertension, uncontrolled dysrhythmias or poor cardiac reserve are excluded from ~~the~~ weight conditioning, group strength training classes, upright elliptical cross trainer machine, **rowing machine, and** ~~or~~ **the** circuit weight/universal gym.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Exercise Protocol, Phase II**

REVISION DATE: 06/97, 03/03, 01/08, 01/13, 08/20

Cardiac Rehabilitation Approval:	**~~02/20~~09/23**
Division of Cardiology Approval:	**~~07/20~~10/23**
Medical Executive Committee Approval:	**~~07/20~~10/23**
Administrative Approval:	**~~08/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To establish guidelines for exercise protocols that ensures patients safety and efficient equipment usage.

B. **POLICY:**

1. All patients in Phase II of the Cardiac Wellness Program shall follow this procedure for exercise.

C. **GENERAL GUIDELINES:**

1. Cardiac rehabilitation patients shall attend at least 75% of the prescribed exercise sessions, which are held three times a week.
   a. Entry blood pressure, pulse rate, and body weight are recorded on the patient's **exercise prescription**~~record~~**. Blood glucose measurements are recorded before and after exercise as indicated.**
   b. Telemetry monitoring systems are connected and recorded.
   c. Warm-up and stretching exercises are performed prior to exercise for 5-10 minutes.
   d. Aerobic capacity and intensity are monitored during peak exercise through measurements of heart rate, blood pressure, and perceived exertion.
   e. The patient is responsible for learning pulse rate monitoring and documentation.
   f. Cool-down and stretching exercises are performed for 5 to 10 minutes.
   g. Exercise modality and intensity, exercise ~~time~~**duration**, exercise blood pressure, exercise pulse rate, and perceived exertion scale are recorded on the patient's record.
   h. Patients are responsible for informing the cardiac rehabilitation staff of any changes in their medical condition, medication changes, signs and symptoms of cardiac insufficiency, and/or any health related information.
   i. Medical Director and/or the supervising physician shall be readily available at all times to review exercise prescriptions **and daily session reports**, rhythms, answer questions, and assist in emergency situations for Phase II and ~~I~~**VI**~~I~~ patients.
2. Phase II participants shall be asked to attend education lectures (1 every ~~other~~ month) regarding risk factor modification. These lectures shall include, but not be limited to Risk Factor Modification, Nutrition, Exercise, Stress Management, and a session of general questions and answers with staff and dietician. In addition to the risk factor lectures, a DVD series of risk factor reduction topics~~,~~ **(e.g**~~i.e.~~ diabetes management, nutrition, stress reduction, **secondary risk factors,** and managing heart failure**)** are also available for viewing. A library of education topics is also given to participants on request.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Patient Enrollment Protocol**

REVISION DATE: 06/97, 03/03, 12/05, 01/08, 01/13 08/20

Cardiac Rehabilitation Approval:	**~~02/20~~09/23**
Division of Cardiology Approval:	**~~07/20~~10/23**
Medical Executive Committee Approval:	**~~07/20~~10/23**
Administrative Approval:	**~~08/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To establish guidelines for enrolling new patients into a Cardiac Rehabilitation Program.

B. **POLICY:**

1. Patient must meet criteria for patient selection.
2. Patient's physician will sign referral stating there are no known contraindications to patient exercising at the time of admission.
3. Patient shall sign exercise consent allowing staff to set guidelines for gradually progressive graded exercise.

C. **GENERAL GUIDELINES:**

1. All patients seen by the cardiac rehab staff during their inpatient stay shall be contacted by staff after an appropriate interval of recuperation at home, to **evaluate their recovery**~~find out how the patient is doing~~ and determine interest in our ~~O~~outpatient Cardiac Rehabilitation program.
   ~~2.~~**a.** Patient's physician shall be contacted and admission to Cardiac Rehabilitation requested. Physician approval shall be accompanied by signed referral.
2. **Referrals received directly from a physician's office or medical group will be reviewed to make sure enrollment criteria are met. Staff will then contact the patient, explain the program and determine if they are an appropriate candidate for cardiac rehab.**
3. Insurance authorization shall be obtained by staff members and patient shall agree to be responsible for any difference between amount billed and amount paid by insurance company, as well as any co-payment **or coinsurance** necessary under their insurances contracted benefits.
4. If the patient's primary physician or cardiologist does not feel an exercise stress test is necessary or appropriate, the patient's target heart rate shall be determined and monitored by the Cardiac Rehabilitation staff using age determined target heart ranges and/or rest plus 30 beats (if patient is taking beta blocker medication). The patient's perceived exertion shall **n**ot exceed the Borg Scale of 15.
5. Patient shall come to Cardiac Rehabilitation for **an** intake **session** and a patient history shall be obtained.
   a. Physical, emotional and psychosocial limitations shall be assessed and documented, to ensure maximum benefit and safety of each participant
   b. Relevant medical records shall be obtained and kept as a part of patient's record. These shall include but not be limited to, a discharge summary and recent ECG.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE

ISSUE DATE:	**11/87**	**SUBJECT: Fire Plan (Code Red)**
REVIEW DATE:	**11/90, 11/93, 11/97, 04/06, 06/12, 08/15**	**POLICY NUMBER: 3005**
REVISION DATE:	**11/94, 03/00, 04/03, 10/11, 04/13, 10/15, 03/19, 12/21, 12/22**	

Department Approval:	**~~09/22~~09/23**
Environmental Health & Safety Committee Approval:	**~~09/22~~10/23**
Administration Approval:	**~~12/22~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**

1. To identify the actions Tri-City Healthcare District (TCHD) shall implement to ensure protection of patients, workforce members (WFM) employees, visitors and property from fire, smoke and other products of combustion.
2. To provide instructions on performing the following;
   a. Identifying when to report a fire
   b. Identifying when to initiate a fire alarm
   c. Smoke and fire containment
   d. Using a fire extinguisher
   e. Assisting with relocating and evacuating patients
   f. Identify fire hazards

B. **DEFINITIONS:**

1. Workforce Members (WFM) – Employees, medical staff, and Allied Health Professionals (AHP), volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD
2. RACE – an standardize acronym for the actions to implement when a fire is identified
   a. R: Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance
   b. A: Alarm - activate the nearest fire alarm (pull station) and call PBX operators by dialing "66" and notify them of the "Code Red" fire. All off campus locations dial "911".
   c. C: Contain - close all remaining doors.
   d. E: Extinguish - extinguish the fire if it can be done without endangering yourself or others.
3. PASS – an acronym used to provide instructions for using a fire extinguisher
   a. P: PULL the pin
   b. A: AIM the nozzle at the base of the fire
   c. S: SQUEEZE the handle
   d. S: SWEEP back and forth across the base of the fire
4. Evacuation Plans – Evacuation plans that identify evacuation routes and the location of alarms and firefighting equipment. The plans are posted in all departments, units, and throughout the facility.

C. **POLICY:**

1. WFM will be provided education to use the following acronyms RACE and PASS to assist with remembering the following.:
2. Supervisors are responsible for showing new employees the location of extinguishers and alarm

pull stations during department orientation

3. The Code Red policy will be reviewed by all WFM during orientation.
4. Fire safety will be reviewed annually using a computer-based learning module (CBL). The following topics will be reviewed:
   a. Actions to implement in the event of a fire
   b. How to initiate a fire pull alarm station
   c. Instructions to identify the fire pull alarm stations, location of fire extinguishers, and evacuation map on their assigned departments
5. AHP, Volunteers, Medical Staff, students, and non TCHD personnel do not have a defined role in the fire response plan and should remain in their current location at the time a fire alarm sounds and render assistance under the direction of the department leadership team as needed.

D. **PROCEDURE:**

1. When a fire or smoke is observed, staff will notify the public broadcast exchange (PBX) via telephone and if possible activate a fire pull alarm.
   a. The PBX operator will announce using the overhead page system "Code Red" and the location of the code red three times.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these WFMare to stop their work and go immediately to the area indicated by the overhead page system.
   d. An Engineer Leader will take immediate charge of the Fire Response Team. In his or her absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.
   e. Patients are not to be evacuated from floors without the order of the Incident Commander or designee. If it is apparent to the Department Director/or designee an evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.
   f. Engineering will clear the fire alarm after the fire is secured.
   g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.
   h. The hospital Public Broadcast Exchange (PBX) Operator will announce on the overhead page system "Code Red All Clear" when fire is secure.
2. Code Red (Implementing a Code Red in Your Work Area):
   a. Remove patients and other persons from immediate danger.
   b. Go to the nearest fire alarm pull station and pull the handle to activate the alarm.
   c. Dial "66" to report "Code Red." Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".
   d. Extinguish fire if it is safe. Use a fire extinguisher to attempt to bring fire under control using the acronyms RACE and PASS – See addendum A
      i. If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.
   e. Check for smoke and flames in other rooms then close all doors.
   f. Stand by to assist as needed.
3. Fire in Patient's Room:
   a. Patient's bed in flames:
      i. Remove the patient from bed to a safe place such as another bed, chair or hallway.
      ii. Depress the nurse call button in the bathroom for immediate assistance. Do not take a smoldering bed out of the room.

iii. Close the patient's room door once the patient is out.
iv. Activate the fire alarm pull station nearest to the fire.
v. Call PBX Operator, dial "66". Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".

4. Area Not Evacuated Secondary to the Condition of the Fire:
   a. Provide maximum protection:
      i. Instruct people to stay in their rooms with the door closed.
      ii. Reassure patients of their safety.
      iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.
   b. If safe to do so one WFM must remain in the corridor to assist fire department upon their arrival.
5. Evacuation
   a. Always use stairs, never the elevator, during a fire.
      i. If evacuation is ordered for an area, the following are methods to be used:
         1) Blanket Carry
         2) Two Person Carry
      ii. Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after an evacuation .is completed.
      ~~iii. Remove Medical Records if possible.~~
      iii. Review the evacuation plans to identify the most appropriate evacuation route.
6. **Types of Evacuation**
   a. Horizontal Evacuation or Relocation
      i. The action taken to move patients from the immediate area of the emergency to an area of safety or an adjacent smoke compartment generally on the same floor.
      ii. Under the direction of the IC/designee leaders in the area may implement relocation.
   b. Vertical Evacuation
      i. The action taken to move patients from one floor to another for safety.
   c. Building Evacuation
      i. This involves removal of all persons from the medical center and requires a plan for implementation.
      ii. Evacuation should only be performed under the direction of the IC and/Fire Department. This would encompass moving all patients, visitors, and workforce to an alternate care site.
      ~~iv.~~**iii. Refer to evacuation plan as needed.**
~~6.~~**7.** Fire Hazards:
   a. Never prop open fire doors.
   b. Hallways must be kept clear at all times.
   c. Never place flammable liquids or oxygen near an ignition source.
   d. Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
   e. . Do not store items to obstruct sprinkler heads, maintain an 18" minimum clearance from the items and the sprinkler heads)
   f. If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.
~~7.~~**8.** Duties of Personnel
   a. Review the Fire Safety Program, evacuation routes, and your responsibilities identified policies and procedures
   b. Participate in all fire drills and practice sessions as required.
   c. Study the fire alarm code and how to report a fire - Dial "66". Affiliated campus locations dial "911".

d. Identify the locations of and how to operate the fire alarm pull stations and fire extinguishers.
e. Observe the "No Smoking" rules.
f. Never store flammable liquids in your desk or cabinet.
g. Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
h. Properly dispose of waste or rags used with cleaning solvents per manufacturer's instructions.
i. Do not use portable heating units.
    i. These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering,
    ii. No portable heaters are allowed in patient care areas.
j. California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.
    i. If necessary, fire response will be coordinated via CDCR staff for custody patients' evacuation.
k. Switchboard personnel:
    i. If the fire is in the area of the PBX office follow the steps outlined in the general instructions section.
    ii. If the fire is not threatening the PBX office initiate the steps below:
        1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, I immediately:
            a) Notify the Fire Department, giving the address and location of the fire in the hospital.
            b) Notify all personnel through the use of the public address system. Use the following code:
                i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.
        2) Prepare the switchboard for emergency operations only, restricting calls.
        3) Notify:
            a) Safety Leader
            b) Administrator On-call
            c) Administrative Supervisor on duty
            d) Security Supervisor or Lead
            e) Director of Engineering
            f) Emergency Department Clinical Leader
            g) Other key personnel, as needed
        4) Implement administrative orders as directed.
        5) If PBX system is inoperative, use the RED phones system or cell phones.

E. **FIRE HAZARDS:**

1. Hazards that WFM shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:
    a. Careless Smoking – Observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes and vapor devices).
    b. Exit Ways - Do not obstruct aisles, doorways, fire escapes or allow their use as storage places.
    c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container.
        i. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.

d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.

e. Flammable Liquids - (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

h. Electric Heaters - These units, particularly the portable type, are not permitted anywhere on the hospital premises unless approved by Engineering. No portable heaters are allowed in patient care areas.

i. Heat generating devices or substances such as candles, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker. Persons who do not comply with these directions will be subject to the disciplinary process.

Addendum A

What is the Fire Plan?

- **R**escue anyone in danger and close the door on your way out
- **A**larm – pull the pull-station and **dial 66**

- **C**ontain the fire by closing other doors in the area
- **E**xtinguish the fire if you can. Evacuate if necessary

How is a fire extinguisher used?

- **P**ull the pin
- **A**im at the base of the fire
- **S**queeze the handle
- **S**weep from side to side

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE: 11/87 **SUBJECT: Life Safety Management Plan**

REVISION DATE: 03/00, 04/06, 04/09, 04/13, 05/12, 06/15, 12/17, 03/19, 12/21, 12/22

Department Approval:	~~09/22~~08/23
Environmental Health & Safety Committee Approval:	~~10/22~~09/23
Administration Approval:	~~12/22~~12/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **EXECUTIVE SUMMARY:**

1. ~~1.~~ Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the workforce and medical staff who use and manage it, and to others who enter the environment.
2. ~~2.~~ The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD.
3. ~~3.~~ The Life Safety Management plan describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities.
4. ~~4.~~ The Life Safety Management plan is evaluated annually to determine if it accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
5. ~~5.~~ The program is applied to the Tri City Medical Centers, and all service lines under its license.

B. **PRINCIPLES:**

1. All buildings of TCHD housing patient care services must be designed, operated, and maintained to comply with the current edition of the National Fire Protection Association (NFPA) Life Safety Code, and the current edition of the NFPA Health Care Facilities Code.
2. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
3. All workforce members (WFM) must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
4. Appropriate temporary administrative and Facilities controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

1. The objectives of the Life Safety Management plan are to provide a physical environment free from physical harm and hazards created by the risk of fire, or products of combustion for the patient care population, staff, volunteers, physicians and visitors. The risk of fire carries with it the

most significant single threat to the environment of care as our patients are routinely incapable of self-preservation, and must rely on correct staff response and building for protection features to assure their safety.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Facilities or designee assures that an appropriate maintenance program is implemented. The Director of Facilities or designee also collaborates with the Safety Manager to develop reports of Life Safety Management performance for presentation to the Environmental Health and Safety Committee (EHSC) on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner.; technicians and service company WFM complete necessary repairs.
3. WFMs are responsible for being familiar with the risks inherent in their work, present in their work environment, and implementing appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace incidents.
4. The Board receives regular reports of the activities of the Life Safety Management program from the EHSC. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Facilities or designee and appropriate clinical WFM. The Board collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
5. The CEO or designee receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Facilities or designee and other appropriate staff to address fire safety issues and concerns.

E. **ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:**

1. Life Safety Management Plan
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of TCHD experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property
   a. The Director of Facilities or designee and Safety Manager are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Facilities or designee and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to ensure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Facilities or designee assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer or designee permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services.
   c. Management
      i. The Director of Facilities or designee oversees the design, implementation, and documentation of processes designed to assure optimal performance and

continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.

ii. The Director of Facilities or designee is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process

i. The Safety Manager is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of TCHD. The current fire response plan is based on the removal from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.

ii. The emergency number "66" is to be dialed to report a fire.

iii. The buildings located on the Medical Center campus will dial "66" to report a fire.

iv. Off-Site building will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds

a. TCHD has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.

b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.

c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

4. The hospital maintains free and unobstructed access to all exits

a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds/tours activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Manager, and the EHSC.

5. The hospital has a written fire response plan

a. The Safety Manager is responsible for coordinating the implementation of the fire response plan. The WFM are oriented:

i. To the R.A.C.E. response method and P.A.S.S. acronym for use of a portable fire extingusisher.to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.

b. The department and area specific fire response plans include information about:

i. The roles of all WFM, medical staff, volunteers, contract staff and students near the point of fire origin.

ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

1) Note: TCHD believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the

area as needs arise.

iii. Operation of the fire alarm system.

iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

6. Fire Drills
   a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
   b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
   c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
7. Inspection, Testing, and Maintenance of Fire Safety Systems
   a. The Director of Facilities or designee works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the NFPA or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes.
   b. The hospital conducts monthly evaluations of nuclear-powered exit signs and verified for expiration dates and replaced accordingly.
   c. Deficiencies are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Supervisor or designee evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Leader.
8. Life Safety Management
   a. The Director of Facilities or designee is responsible for maintaining the Statement of Conditions. The Director of Facilities or designee prepares a quarterly report of the rate of completion of any Plan for Improvement for the EHSC. If any items will not be completed within the established timeframe the Director of Facilities or designee is responsible for preparing a letter to the Joint Commission requesting an extension of the timeframe or a change of the method of correction.
9. Management of Fire Safety Risks
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
   b. The Director of Facilities or designee and Safety Manager are responsible for implementation of the ILSMP may include training, installation of Facilities controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
   c. The Director of Facilities or designee and Safety Manager are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Manager and/or the Director of Facilities or designee take appropriate action

to resolve the deficiencies.

d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented and presented to the EHSC as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

10. The hospital monitors conditions in the environment
    a. The Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Manager works with the Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, WFM incidents, and property damage related to environmental conditions.
    b. Incident reports (RLs) are completed by a witness or the WFM to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, Risk Management and the Safety Manager collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the EHSC and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Manager provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
    d. The Safety Manager coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, and support services, and department managers are consulted to analyze safety and environmental issues and to develop recommendations for addressing the identified risks.
    e. The EHSC and the PSC are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
    f. The Safety Manager prepares a quarterly report to the leadership of TCHD that summarizes key issues and recommendations reported to the committee.
    g. The quarterly report also communicates information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. Semi-annual EOC activity reports are provided to the Board of Directors.

11. Annually (approximately every twelve months) the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.
    a. The Safety Manager coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources that include aggregate analysis of environmental rounds and incident reports; findings of external reviews or assessments by regulators; accrediting bodies, insurers, and consultants: minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year, as well as, an action plan to address identified weaknesses.

c. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Leaders.

d. The EHSC reviews and approves the annual reports. Actions and recommendations of the committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, Board of Directors, the PSC, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues
    a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
13. Improving the Environment
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with EHSC recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient Safety Manager ship.
14. Orientation and Ongoing Education and Training
    a. Orientation and training addressing subjects of the environment of care is provided to each WFM, volunteer, and to each new medical staff member at the time of their employment or appointment.
    b. Current WFMs complete an annual review of life safety via a Computer Base Learning (CBL) module and documented in the Netlearning system.
    c. The Human Resources (HS) Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program per TCHD policies and procedures.
    d. The Safety Manager collaborates with the managers, Regulatory and Infection Control, the PSO and others as appropriate to develop content materials for general and job-related orientation and continuing education programs.
        i. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
    e. The Safety Manager gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job-related risks are to be managed or eliminated as part of daily work. The Safety Manager evaluates the degree to which WFMs understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    f. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **EFFECTIVENESS:**

1. Program effectiveness will be regularly monitored using significant incidents as well as trending of performance measures to indicate the effectiveness of the processes and/or systems in place. Performance monitoring and assessments of program effectiveness will be reported to TCHD Environmental, Health & Safety Committee. Significant events and outcomes of regular trending are reported by the Safety Manager to the EHSC committee annually or immediately as an expectation for serious events.

G. **ANNUAL GOALS/OBJECTIVES ~~FOR 2023~~:**

1. ~~1.~~ Comply with regulatory standards of fire drill requirements.
2. ~~2.~~ Conduct at least 15 random tracers quarterly inspecting fire rated doors for compliance with NFPA 80.
3. ~~3.~~ Conduct at least 10 random tracers quarterly in conjunction with EOC rounds insuring proper compliance with specific clearance for fire extinguishers, pull-down stations and electrical panels.
4. Provide annual Fire extinguishers training to the maintenance department staff.

H. **REFERENCE(S):**

1. The Joint Commission (TJC). (2021). Accreditation Requirements.
2. The 2012 Edition NFPA 101 Life Safety Code
3. The 2012 Edition NFPA 99 Health Care Facilities Code

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL
~~POLICY~~

ISSUE DATE: 08/17 **SUBJECT: Ebola Plan**

REVISION DATE~~(S)~~: 12/20

Department Approval:	**~~07/202~~09/23**
Infection Control Committee Approval:	**~~08/20~~09/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/20~~10/23**
Administration Approval:	**~~12/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/20**

A. **PURPOSE:**

1. To standardize the risk assessment, triage, transportation, and management of patients with possible/confirmed Ebola Virus Disease (EVD) throughout Tri-City Medical Center (TCMC) and its affiliated facilities.

B. **INTRODUCTION AND BACKGROUND:**

1. Ebola virus (EV) was first discovered in 1976 near the Ebola River in the Democratic Republic of Congo. The virus has been infecting people from time to time since then leading to outbreaks in several African countries. Scientists believe that the virus is animal-borne, with bats or nonhuman primates being the most likely source. Infected animals carrying the virus can transmit it to other animals and humans. The virus spreads to people initially through direct contact with blood, body fluids and tissues of animals. EV then spreads to other people through direct contact with body fluids of an infected person or a person who has died from EVD.
2. Pregnant women with EV appear to be at an increased risk of fetal loss and pregnancy associated hemorrhage. Ebola virus can cross the placenta, and pregnant women infected with the virus will likely transmit it to the fetus. The risk of spontaneous fetal loss is high.
3. While the risk of importation of Ebola virus into California remains very low, infectious diseases can be introduced by returning California residents and global travelers visiting the state. The U.S. Centers for Disease Control and Prevention (CDC) recommends that all hospitals in the U.S. be prepared to care for patients who could have EVD.

C. **TCMC IS CONSIDERED A FRONTLINE HEALTHCARE FACILITY ACCORDING TO CDC, WHOSE ROLE IS TO:**

1. Rapidly identify and triage patients with relevant exposure history AND signs and symptoms compatible with EVD.
2. Immediately isolate any patient with relevant history and signs and symptoms of EVD and take appropriate steps to adequately don personal protective equipment (PPE) to protect staff triaging and caring for the patient.
3. Immediately notify hospital Infection Control, appropriate facility staff and local public health agency.
4. Frontline healthcare facilities, in accordance with the state's plan, should consider immediately transferring patients who have a higher probability of EVD or are more severely ill to an Ebola treatment center (University of California San Diego Medical Center; San Diego, California) that can provide Ebola testing and care for the higher risk patients until an EVD diagnosis is either confirmed or ruled out.

D. **ABOUT EBOLA:**

1. While Ebola is a dangerous virus that can be life-threatening, its spread can be contained.
   a. EVD is spread by contact with blood or any other body fluid from a person with symptoms of EVD infection. Infection is spread when infected body fluids come in contact with mucous membranes, breaks in the skin or by sharps injuries.
   b. EVD is not transmitted through the air unless there is exposure to body fluid droplets from an infected person (e.g., coughing, sneezing or spitting).
   c. EVD is not transmitted from persons who don't have symptoms of infection (see below for symptoms of EVD infection).
2. EVD usually starts with a sudden onset of fever along with symptoms, including chills, weakness, abdominal pain, joint muscle aches, headache, lack of appetite and body aches. Vomiting and diarrhea are common. In severe cases, internal and external bleeding may occur.
3. The illness begins an average of 8-10 days following exposure (although it could be from 2 to 21 days).
4. Some of the symptoms of EVD are similar to those of other infections that are common in West Africa, such as malaria and diarrheal illnesses.
5. There currently are no FDA-approved medications specific for treating Ebola virus infection. The main way we treat EVD is through supportive care. This means providing excellent medical and nursing care, including monitoring and replacing fluids and electrolytes, as well as transfusions as necessary. The goal is to provide this care to the patients until their bodies can control the virus.

E. **ASSUMPTIONS:**

1. Risk assessments will be done for patients entering our system through numerous routes, including:
   a. Emergency Department (ED)
   b. Labor and Delivery
   c. Walk in entrances as indicated by patient presentation
2. Procedures for risk assessments and screening at points of entry will include:
   a. Questioning about travel history within the past 21 days before illness onset, exposure risk, and history of febrile illness as provided below.
3. TCMC patients with suspect EVD will be triaged, isolated on site and transferred to the Ebola treatment center UCSD, under the direction of San Diego County Public Health. Single patients will remain in the ED room 26 for the duration of their hospitalization and necessary supplies and equipment will be provided in that location.
4. Obstetric patients over 20 weeks will be managed in ED room 26 with the support of the Labor and Delivery staff.
5. Patients will be transferred to University of California, San Diego Hospital in collaboration with the County of San Diego Public Health for definitive care.
6. General Incident Command Structure (HICS) will be activated during the period of time a patient with suspected EVD is within TCMC. The mission and direction will be provided by the Incident Commander with input from the Medical/Technical Specialists. The Incident Response Guide: Infectious Disease (HICS, 2014) will be utilized as a framework for general HICS response.

F. **RISK ASSESSMENT:**

1. Because travel to high-risk areas is one of the risk factors for transmission, these guidelines address patients who are considered at high risk for EVD who meet travel criteria. In addition, exposure to a known EVD patient has also been included in the assessment. Upon initial arrival to one of the entry points into the system, patients will be screened for a positive travel history and symptoms consistent with EVD.
2. High-risk of EVD (Refer to CDC Checklist for Patients being Evaluated for EVD in the U.S.)
   a. High-risk exposure (defined below) plus ANY symptoms suggestive of EVD (fever [subjective or > 38 degrees C, 100.4 degrees F] and/or other symptoms, including

severe headache, muscle pain, vomiting, diarrhea, abdominal pain, bleeding). High-risk exposure is defined by the CDC as:

i. Percutaneous (e.g., needle stick) or mucous membrane exposure to body fluids of confirmed or suspected EVD patient
ii. Direct care of an EVD patient or exposure to body fluids from such a patient without appropriate personal protective equipment (PPE)
iii. Processing body fluids of confirmed EVD patients without appropriate PPE or standard biosafety precautions
iv. Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring

b. Low-risk exposure (defined below) plus high probability of infection based on clinical assessment.
   i. Low-risk exposure defined by the CDC as:
      1) Household contact with an EVD patient
      2) Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as:
         a) Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended PPE (i.e., standard, droplet and contact precautions)
         b) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended PPE
      3) NOTE: Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.

G. **DOCUMENTATION:**

1. Nursing documentation of EVD Risk Assessment will be documented in the Cerner Triage Form v2 for patients entering the ED. Patients arriving for Labor and Delivery care will have risk assessment documentation placed in the OB nursing intake assessment form in Cerner.
2. Initial Triage: (Refer to CDC Checklist for Patients being Evaluated for EVD in the U.S.)
   a. The following actions will be taken for patients who demonstrate the following:
      i. Identify Exposure History (needs to meet one of the two below):
         1) a travel history to an affected country within the last 21 days
         2) contact with an individual with Ebola within the last 21 days
      ii. And one of the signs and symptoms of Ebola below:
         1) Fever: ≥100.4 F or 38.0 C or the following Ebola compatible symptoms:
            a) Headache
            b) Fatigue
            c) Weakness
            d) Muscle Pain
            e) Vomiting
            f) Diarrhea
            g) Abdominal Pain
            h) or Hemorrhage (bleeding gums, blood in urine, nose bleeds, coffee ground emesis or melena).
   b. If both i. and ii. are met (exposure history and signs and symptoms consistent with Ebola Virus Disease), the following measures should be implemented <u>immediately</u> in accordance with CDC recommendations.
   c. If only i. (the exposure/travel history) is met and not symptoms, continue with usual triage & notify public health for further guidance.
3. Initial Actions (if above is met):
   a. Mask patient immediately. Do not place in waiting room. Instruct patient to wait outside briefly in patio area away from other patients or visitors.

b. Immediate triage staff don personal protective equipment (PPE), the minimum being a hooded Tychem suit, water resistant gown, double gloves, **fitted** N95 mask*, goggles, face shield and knee high shoe covers.
   i. If patient is exhibiting bleeding, vomiting, diarrhea then a PAPR should be utilized.
      1) Additional full PPE will be donned by all direct care providers in the ante room adjacent to ED room 26 (See PPE Guidance Matrix by Job Positions and Job Checklists).
c. Contact Security to assist with controlling the area. Security will also obtain the names of those are in the proximity of the patients.
d. Prior to placement of patient in room C26: room must be prepared to accept patient
   i. See job role (Job Checklists).
e. ED Charge to assign job roles. (Job Checklists)
f. Contact the ED charge RN and instruct them to unlock the exterior door to room 26.
   i. See ED Charge Nurse Job Descriptions for further initial actions (see Job Checklists).
g. Escort patient OUTSIDE to the exterior entrance to room 26.
h. Place "CONTACT, AIRBORNE" isolation and STOP signs on interior door. All dirty linens and supplies are to remain in the room with the patient.
i. Contact Engineering to start monitoring the negative pressure room (C26) and to Contact ATI company to set up anteroom and Decon Room outside C26 (Diagram).
j. Don all recommended PPE for direct care provider prior to entering the room for patient care.
k. Post a designated assistant outside the room to monitor/assist PPE use and hand hygiene (see job description, Job Checklists)
l. Post a designated observer outside of room to monitor staff who enter/exit room. Take vital signs of staff before Donning and after Doffing of PPE (see job descriptions- Job Checklists and Observer Tracking Form).
m. Contact Administrative Supervisor, Infection Control, and Public Health (619-692-8499(Mon-Fri) or 858-565-5255 (after hours) as per posted advisement. Await direction from Public Health for ordering of labs, diagnostic studies, etc.
n. Contact EVS STAT for any contamination to public areas and to restrict access to any potentially contaminated areas.
o. Observer role: Document all staff who cared for patient and/or entered the room (see appendix for the form) Observer Tracking Form. Limit the amount of staff entering the room.

H. SPECIMEN MANAGEMENT FOR HIGH-RISK TESTING:

1. Guidelines for handling/testing specimens from suspected cases of Ebola virus disease:
   a. General Considerations:
      i. Initial testing of patients upon presentation shall be limited to the CDC-required PCR testing for confirmation of Ebola. All testing will be guided by the County of San Diego Public Health (CDPH) Epidemiology department (along with Infection Control and the Laboratory)
      ii. There will be **no** transport of specimens to the Laboratory.
      iii. Specimen processing should be performed in the patient's room or nearby in a contained testing area.
   b. Specimen Collection:
      i. In order to limit the number of TCMC employees involved in the patient's care and to limit exposure, an RN already inside the patient's room will draw 2 tubes of blood and place each tube in separate biohazard bags that another RN within the room is holding.

ii. A minimum volume of 4 ml of whole blood preserved with EDTA or SPS (Sodium polyanethol sulfonate) in plastic vacutainer tubes should be drawn for EVD testing. Do not collect specimens in glass containers.
iii. The specimen, enclosed in a small cold pack, will then be transported to the ante-room for pick-up by the San Diego County Public Health (SDPH) Microbiologist.
iv. Immediately contact the San Diego County Public Health (SDPH) Epidemiology Program by phone at 619-692-8499 (Mon-Fri) or 858-565-5255 (after hours).
v. San Diego County Public Health (SDPH) Epidemiology will assess the request, and will, if warranted, contact SDPH Laboratory.
vi. SDPH Laboratory will send a specifically trained Public Health Microbiologist, with packaging and shipping materials, to the specially designated TCMC patient care containment area.
vii. The trained Public Health Microbiologist will prepare documents, prepare and package specimens, and arrange for shipment to the CDC and Los Angeles County Public Health laboratory for PCR testing.
viii. Fill up the attached Primary Specimen Contact List to record all personnel who come into contact with the specimen, including contact with primary specimen container.

2. Laboratory procedures for consideration while waiting for PCR results:
   a. NOTE: Unless critically needed, do not perform any additional laboratory testing. Rapid Point 500 instrument should be ordered from the lab. If Rapid Point 500 instrument is used, it will need to be kept in containment area for later cleaning with other supplies.
   b. Chemistry, Hematology:
      i. Blood gases, electrolytes, hemoglobin, hematocrit
      ii. Testing should be limited to Rapid Point 500 and should only be performed in the patient's room by the RN.
   c. Urinalysis:
      i. Available as a urine dipstick and performed in the patient's room.
      ii. .
   d. Blood Cultures:
      i. Contact SDPH if required.

I. EVALUATING PATIENTS FOR EBOLA VIRUS AT L&D ENTRY

1. Initial Intake:
   a. DAYS: Secretary will have patients fill out the intake questionnaire at front desk, where (2) EBOLA specific questions have been added. If the patient answers "YES" to BOTH questions, the patient will be given a mask to wear and instructed to sit in wheel chair away from other patients. The charge nurse will be called and the patient immediately transported to Room #201 on 2S.
   b. NOCS: Before the patient is allowed access to the L&D Unit, the (2) EBOLA specific questions will be asked over the phone. If the patient answers "YES" to BOTH questions, will NOT be given access to the unit. Staff will bring the patient out a mask to wear, wheelchair, and escort to Room #LDR 3 with window open and door closed.
2. Initial PPE Precautions for staff transporting the patient:
   a. The staff member shall follow Standard, Contact and Droplet precautions and wear:
      i. White bunny suit
      ii. Gloves (2) pairs if desired (double donned)
      iii. Surgical Mask with face shield/ eye protection OR Surgical Mask and goggles(KITS have been made and are located on top of the File Cabinet in the Managers hallway)
      iv. Before removing the PPE, another staff member must be present to ensure correct removal practice.
3. Main Goals:

a. To contain spread of the virus (masking patient) and transport patient to secure location for containment (LDR 3).
b. Once patient is secure in LDR 3, notify the Administrative Supervisor (AS) and also L&D Nursing Chain of Command, so staffing items can be discussed.

4. Ongoing Precautions:
   a. A more DETAILED, DOUBLED DONNED, PPE process will need to occur once the patient is moved to LDR 3 by the staff member expected to assess and care for the patient. Hang PPE supplies on door and place isolation sign on door. Staff SHOULD NOT re-enter the room without this more detailed level of PPE protection.
   b. A BUDDY System to both APPLY and REMOVE PPE, will be required.
   c. All removed items from staff (PPE) and the patient's room (waste, etc.) will have specific disinfection needs and will be disposed of in an identified container.
   d. If patient is admitted and in labor, she will labor and deliver in room LDR 3 then remain in same room for post--partum care. LIMITED MOVEMENT of the infected person is what is BEST.
   e. Staff entering the room will be restricted to essential personnel ONLY (RN/Provider/ OB Tech, etc.) Items needed for care (supplies, meds, etc.) will be BROUGHT to the ROOM by an outside source
   f. A log of who enters the patient's room will be kept for any follow-up needs.
   If delivery does occur, MOM and BABY may be separated and isolated from each other, Baby will be placed in an isolette. All caregivers must -wear PPE while caring for baby.

J. **EDUCATION:**
   a. System-wide education for PPE use will be provided to all staff in high risk patient care areas (ED, RT, EVS) as well as any staff who are interested. Education will include hands on practice in donning and doffing minimum required PPE, according to CDC recommendations. Advanced PPE, including PAPR use will be provided to direct care providers in high risk areas (ED, RT).
   b. Netlearning trainings are available on the doffing and donning of PPE.
      i. Education for Donning and Doffing of PPE for all staff is located on the TCMC Intranet>Departments>Clinical>Clinical References>Ebola Virus Disease References: Donning and Doffing in Ebola Virus Disease.
   c. Employee Health Services (see Employee Health Management EVD Protocol)
   d. Employee Health Services (EHS) is charged with establishing medical evaluation, surveillance procedures and ongoing review of the health status of all personnel in the event of a potential Ebola Virus Exposure. Employee Health Services will follow guidance as directed by the County of San Diego Public Health Epidemiology, CDPH and CDC.

K. **FORM(S):**
1. Potential Exposure Contract List – Sample
2. Observer Tracking Form – Sample

L. **EXTERNAL LINK(S):**
1. Online Skills: Isolation Precautions: Ebola Donning and Doffing Personal Protective Equipment

M. **RELATED DOCUMENT(S):**
1. CDC: Checklist for Patients Being Evaluated for EVD in the United States
2. Direct Health Care Provider Symptom Questionnaire (EVD)
3. Employee Health Management EVD Protocol
4. Job Checklists
5. PPE and Cleaning Supply List
6. PPE Guidance Matrix by Job Positions

7. PPE Guidance Matrix for EVD
8. Room Diagram
9. Room Signage

N. **REFERENCES:**

1. CDC General Information: https://www.cdc.gov/vhf/ebola/index.html **(reviewed 8/23)**
2. CDC For Clinicians: https://www.cdc.gov/vhf/ebola/clinicians/index.html **(reviewed 8/23)**
3. CDC for Pregnant Women: https://www.cdc.gov/vhf/ebola/clinicians/evd/pregnant-women.html **(reviewed 8/23)**
4. CDPH Ebola Virus Disease: Information for Health Professionals: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx **(reviewed 8/23)**
5. San Diego County Health & Human Services: Ebola: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/ebola.html **(reviewed 8/23)**

Potential Exposure Contract List – Sample

Tri-City Medical Center

Potential Exposure Contact list

Date:

Name	Location in Hospital	Approximate Arrival Time	Address	Phone number

Security Officer Name: _____

Observer Tracking Form – Sample

Tri-City Medical Center

Observer Tracking Form: Health Care Workers Entering Patient Care Room

Health Care Worker Name	Employee ID	Vital Signs prior to Donning (B/P, T, P, R)				Time Entered Room	Time Exited Room	Vital Signs after Doffing (B/P, T, P, R)			
		B/P	T	P	R			B/P	T	P	R

Date: _____ **Observer Name:** _____

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Assess the patient for a fever (subjective or ≥ 100.4°F / 38.0°C)
- ❑ Determine if the patient has symptoms compatible EVD such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage
- ❑ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset
  Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present
  See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Upon initial assessment

- ❑ Isolate patient in single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital Infection Control Program at _____
- ❑ Report to the health department at _____

Conduct a risk assessment for:

High-risk exposures

- ❑ Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids from an EVD patient
- ❑ Direct skin contact with skin, blood or body fluids from an EVD patient
- ❑ Processing blood or body fluids from an EVD patient without appropriate PPE
- ❑ Direct contact with a dead body in an Ebola-affected area without appropriate PPE

Low-risk exposures

- ❑ Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

Use of personal protective equipment (PPE)

- ❑ Use a buddy system to ensure that PPE is put on and removed safely

Before entering patient room, wear:

- ❑ Gown (fluid resistant or impermeable)
- ❑ Facemask
- ❑ Eye protection (goggles or face shield)
- ❑ Gloves

If likely to be exposed to blood or body fluids, additional PPE may include but isn't limited to:

- ❑ Double gloving
- ❑ Disposable shoe covers
- ❑ Leg coverings

Upon exiting patient room

- ❑ PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials
- ❑ Discard disposable PPE
- ❑ Re-useable PPE should be cleaned and disinfected per the manufacturer's reprocessing instructions
- ❑ Hand hygiene should be performed immediately after removal of PPE

During aerosol-generating procedures

- ❑ Limit number of personnel present
- ❑ Conduct in an airborne infection isolation room
- ❑ Don PPE as described above except use a NIOSH certified fit-tested N95 filtering facepiece respirator for respiratory protection or alternative (e.g., PAPR) instead of a facemask

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment (if possible)
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnostics and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses**

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing***
- ❑ Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete
- ❑ Evaluate for evidence of bleeding and assess hematologic and coagulation parameters
- ❑ Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
- ❑ Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

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* See 2014 Ebola Outbreak in West Africa—Case Counts or http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html to determine if a country has widespread Ebola transmission

** See Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus or http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html

*** See Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Persons Under Investigation for Ebola Virus Disease in the United States or http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

Tri-City Medical Center

Direct Health Care Provider Symptom Questionnaire (EVD)

Direct Health Care Provider (including Lab Personnel and Anyone Managing the Waste Stream) Symptom Questionnaire (EVD)

Name_____

Employee ID #_____

Date_____

Time _____

Cell phone number (best contact #) _____

1.	Temperature:_____	degrees C/F		If yes, onset and duration
2.	Nausea/Vomiting:	N_____	Y_____	_____
3.	Diarrhea:	N_____	Y_____	_____
4.	Headache:	N_____	Y_____	_____
5.	Joint or Muscle Aches, or both	N_____	Y_____	_____
6.	Stomach Pain:	N_____	Y_____	_____
7.	Lack of Appetite:	N_____	Y_____	_____
8.	Weakness:	N_____	Y_____	_____

1. All health care providers providing direct patient care (including lab personnel and anyone managing the waste stream) are **required** to complete this form at the beginning and at the end of their shift.
2. If you have a fever of ≥ 37.8 degrees C, 100 degrees F, or any of the symptoms listed above, please call Employee Health Services prior to leaving the Unit.
3. Complete an Employee Injury/Illness Form.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.
5. Any health care provider (including lab and anyone managing the waste stream) are required to monitor their temperature twice daily and monitor for any symptoms (listed above) on days not worked on the Unit. Report these symptoms immediately to Occupational Injury Management. You are required to report any fever of ≥ 37.8 degrees C, 100 degrees F or any of the following symptoms (chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain or lack of appetite) for 21 days from the last shift worked on the Unit.

Signature: _____

Tri-City Medical Center

EVD Response Plan: Protocol for employees providing direct patient care (including lab personnel and anyone managing the waste stream)

A. To provide guidelines for employees who are providing direct patient care to a patient with Ebola Virus Disease. This includes lab personnel and anyone managing the waste stream.

B. **PROCEDURE**

1. All health care providers, including lab personnel and anyone managing the waste stream are **required** to measure their temperature and complete the symptom questionnaire twice daily.
2. Employees are required to report:
   a. Fever of 100 degrees F or equal or greater than 37.8 degrees C
   b. Symptoms of chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain, or lack of appetite.
   c. If symptomatic, **do not** leave the Unit; notify EHS, department manager/ designee and you will be evaluated in the Emergency Department.
3. Employees, who have provided care to a patient with Ebola, are **required** to complete the questionnaire and take their temperature twice a day, for **21 days** from the last shift worked and report to EHS if temperature or symptoms develop.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.

C. **COMPLIANCE**

1. Compliance with this policy is mandatory. Employees who do not comply with this requirement may be subject to disciplinary actions.

Tri-City Medical Center

Job Checklists

A. Job Descriptions Overview:
   1. Observer #1
   2. Observer #2
      a. Please Note: There are two observer positions:
         i. One posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window
         ii. the other posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
      b. In Room Observer (Optional Role)
      c. Assistants
         i. Ante Room Assistant
         ii. Decon Room Assistant
   3. Charge Nurse

Observer #1:

A. Location: posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window (Stationed at all times)
B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation
C. Perform the following activities:
   1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
   2. Limit anyone entering and exiting room
   3. If anyone tries to enter, direct them to the entrance outside C26 Ambulance Bay. (see Diagram in Rom Diagram).
   4. Do not allow visitors (unless approved by Public Health).
   5. Look through window outside of room C26 during patient care activities: Observe practice of worker within room to ensure that worker does not contaminate self (ie. Accidently remove PPE, compromise PPE, etc).
   6. Provide immediate corrective action if the worker does not follow recommended activities.
   7. Should know the exposure management plan in the event of the unintentional break in the procedure
   8. Helps to coordinate patient care rotation

Observer #2:

A. Location: Posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
B. Role: Observe and read aloud each step of the Donning and Doffing of the Worker entering/exiting the patient room. Ensure adherence to the donning and doffing process. Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation
C. Perform the following activities:
   1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
   2. Limit anyone entering and exiting room
   3. Document and record anyone entering and exiting room with corresponding time. (see Observer Tracking Form).
   4. Do not allow visitors (unless approved by Public Health).
   5. Obtain vital signs of worker prior to donning PPE.
   6. Read aloud each step of the donning and doffing procedure. Refer to PPE Guidance Matrix for EVD for each step.
   7. Provide immediate corrective action if the worker does not follow recommended step

8. Should know the exposure management plan in the event of the unintentional break in the procedure
9. Ensure the following after worker leave decon area. Ensure worker has at least a ½ break before resuming activities and rehydrates.

In Room Observer (Optional Role):

A. Location: posted in the patient care room
B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The In Room Observers primary role is not to perform patient care activities but to conduct observation (But may assist with patient care activities as needed).
C. Perform the following activities:
    1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
    2. Do not allow visitors (unless approved by Public Health).
    3. Observe practice of worker within room to ensure that worker does not contaminate self (ie. accidently remove PPE, compromise PPE, etc).
    4. Assist with patient care activities as needed.
    5. Provide immediate corrective action if the worker does not follow recommended activities.
    6. Should know the exposure management plan in the event of the unintentional break in the procedure
    7. Role will transition into primary patient care worker and be replaced by a new In room observer.

Assistants:

A. Ante Room Assistant
    1. Role: Assist the "Clean" worker in the Ante Room to don the PPE.
    2. Perform the following:
        a. Wear appropriate PPE. PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
        b. Assists the "Clean" Worker in donning the PPE under the guidance of the observer
        c. Confirm visually that all PPE is serviceable
        d. Confirm the integrity of the ensemble with no skin or hair visible
B. Decon Room Assistant
    1. Role: Assist the "Dirty" worker in Decon in removing the PPE.
    2. Perform the following:
        a. Wears the same level of PPE as the worker (caring for the patient). PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
        b. Assists the "Dirty" Worker in removing the PPE under the guidance of the observer
        c. Periodically clean the decon area and decon area floors when visibly soiled using EPA approved disinfectant: bleach

Charge Nurse

A. Role: Oversee the management & coordination of the patient care.
B. Perform or assign the following initial steps:
    1. Contact Security
    2. Contact Administrative supervisor (who should contact Infection control)
    3. Contact Public Health (619-692-8499)
    4. Contact Engineering: to start monitoring room and they will call the company to set up decon room containment.
    5. Prepare the Room (C26)*
        a. Cover equipment in room with C-arm
        b. Place commode with red bags in the room
    6. Get the PPE cart from Disaster cage (basement)
C. Perform or assign the following continuing steps:
    1. Oversee additional PPE supply needs

Tri-City Medical Center

High Level PPE Direct Caregiver	Step Down PPE Indirect Care	Cleaning Supplies
Item Description	Item Description	Item Description
TYCHEM SUIT - LG	TYCHEM HOODED SUIT – LG	DISINFECTING DETERGENT 4X 1GAL
TYCHEM SUIT - XL	TYCHEM HOODED SUIT - XL	SANI-CLOTH WIPES -PURPLE TOP
TYCHEM SUIT - 2XL	TYCHEM HOODED SUIT – 2XL	SANI-CLOTH XLG 8X14 PURPLE TOP
LEVEL 4 SURGICAL GOWN – LG GO	N95 MASK – SM, MED, LG	BLEACH WIPES
KNEE HIGH SURGICAL BOOTS - LG	LEVEL 4 SURGICAL GOWN - LG	ABSORBENT 21GR
PLASTIC APRON	KNEE HIGH SURGICAL BOOTS - LG	
PLASTIC SAFETY GOGGLES	PLASTIC APRON	
FACE SHIELD	GLOVE NITRILE 6" - SM, MED, LG	
TYVEK SHROUDED PAPR HOOD	GLOVE NITRILE 8" – SM, MED, LG	
COVER BOOT – LG	FACE SHIELD	
GLOVE NITRILE 6" - SM, MED, LG	PLASTIC SAFETY GOGGLES	
GLOVE NITRILE 8" – SM, MED, LG	SURGICAL HEAD COVER	
DUCT TAPE		
BELT MOUNTED PAPR W CARTRIDGE (OBTAIN FROM SPD)		

Tri-City Medical Center

Role	Observer 1	Observer 2	In Room Observer	Anteroom Assistant	Decon Assistant	Direct Caregiver	EVS
Description of role	Posted outside room to view actions in the room through window. Redirects caregiver when needed to protect from contamination. Provide aide if needed. Link for communication outside room.	Posted outside to direct Donning and Doffing - Reads step by step the donning or doffing process and observes to make certain correctly completed. Observes for any signs of contamination during doffing.	Optional: depends on how sick patient is and how much care is required	Hands on assistance with doffing	Hands on Assistance with doffing	Anyone working inside the patient room	Cleaning outside patient room. (Cleaning inside room, handling linens or trash from inside the room is considered Direct care.
Level of PPE required	Tychem suit Knee high surgical boots Readily available if needed for assistance in room: PAPR with Cartridge Shrouded PAPR Hood Level 4 Surg. Gown Plastic Apron Cover boot 2 pr long nitrile gloves 1 pr. reg nitrile gloves. Duct tape	No PPE necessary	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	No PPE necessary	Same level of PPE as person assisting with doffing. (N95 or PAPR) Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	Correct size N95 mask. (If unable to be fit test N95, must wear PAPR) Tychem suit Level 4 Surg. gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Direct Care Giver –PAPR)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O Long nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvek jumpsuit (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Put on PAPR hood
- O Attach PAPR and secure around waist.
- O Blue surgical gown over the jumpsuit and inside layer of PAPR hood. Tie.
- O Put outer layer of hood down over shoulders.
- O Long Nitrile gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Indirect Care Giver –N95 mask)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O 12" nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvekjumpsuit with hood (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Blue surgical gown over the jumpsuit. Tie.
- O 12" Nitra-gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Bouffant cap if needed to contain hair
- O Proper size N95 mask
- O Goggles
- O Put hood on & zip the jumpsuit the rest of the way
- O Face shield over the hood and tape (with tab) to hood. (No exposed skin or hair)
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

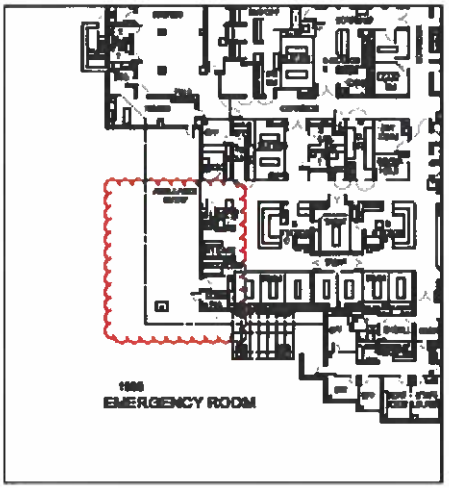
Tri-City Medical Center

A. C 26(Negative Pressure Room): Patient Care room
B. C25 (Inside of ED): Cordon off area. This is controlled area. Do not enter room from this side. This is where Observer #1 observes practice through window.
C. Outside of C26 (Ambulance Bay area): Doffing & Decon area- containment set up by ATI.

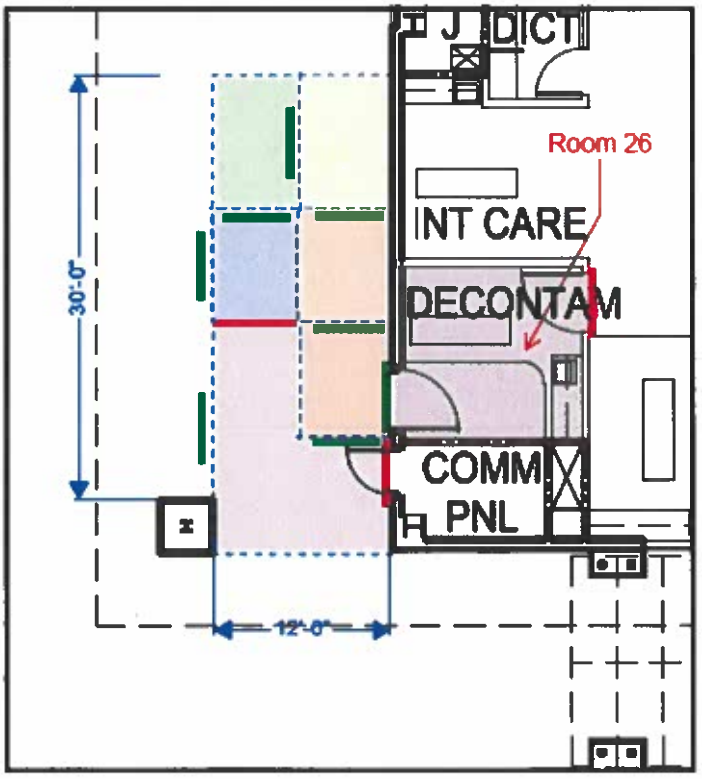
Tri-City Medical Center
Infectious Diseases
Barrier Layout







BARRIER LAYOUT



ADMIT PATHWAY & SUPPLY ROOM
EXIT ROOM
CLEAN ROOM
PPE ROOM
SHOWER ROOM
DIRTY ROOM
ROOM 26

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL POLICY

ISSUE DATE: 01/03

SUBJECT: Prion Diseases: Transmissible Spongiform Encephalopathies (TSE) such as: Creutzfeldt-Jakob disease (CJD) and Variant (vCJD)

REVISION DATE(~~S~~): 01/09, 02/12, 08/17, 02/20

Department Approval:	**~~06/20~~08/23**
Infection Control Committee Approval:	**~~09/20~~10~~09~~/23**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/20~~10/23**
Administration Approval:	**~~12/20~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/20**

A. **INTRODUCTION:**

1. Prion diseases or transmissible spongiform encephalopathies (TSE's) are a family of rare progressive neurodegenerative disorders that affect both humans and animals. They are distinguished by long incubation periods, characteristic spongiform changes associated with neuronal loss, and a failure to induce inflammatory response. The causative agents of TSE's are believed to be prions. The term "prions" refers to abnormal, pathogenic agents that are transmissible and are able to induce abnormal folding of specific normal cellular proteins called prion proteins that are found most abundantly in the brain. This abnormal folding of the prion proteins leads to progressive degenerative brain and nervous system damage. Prion diseases are usually rapid progressive and always fatal. Examples of Human Prion Diseases: Creutzfeldt-Jacob Disease (CJD), Variant Creutzfeldt-Jakob Disease (vCJD), Gerstmann-Straussler-Scheinher Syndrome, Fatal Familial Insomnia, and Kuru. Examples of Animal Prion Diseases: Bovine Spongiform Encephalopathy (BSE or Mad Cow Disease), Chronic Wasting Disease, and Scrapie.
2. Prion diseases are not known to spread by contact from person to person. In the healthcare setting, risk of transmission to patients has been associated with direct contact with infectious tissues (See B.7. Tissue Infectivity). Contaminated surgical equipment or implantation of electrodes deep in the brain can also transmit infectious prions from one patient to another. Transmission has occurred during invasive medical interventions (two confirmed and four unconfirmed cases) after contaminated medical equipment was not properly cleaned before use on another person.
3. The prions that cause TSE's exhibit an unusual resistance to conventional chemical and physical decontamination methods. The infectious agents that transmit prion diseases are resistant to inactivation by heat and chemicals, and therefore require special biosafety precautions. Incineration is the preferred method for all instruments exposed to high infectivity tissues.
4. Prion diseases are transmissible by inoculation or ingestion of infected tissues. A new variant CJD has been linked to eating contaminated beef, elk or deer meat.
5. Symptoms include an insidious onset of confusion, progressive dementia, variable ataxia, seizures, visual or sensory deficits, and rapid mental deterioration in patients' aged 16+, most frequently between 40 and 70 years old. Incubation period ranges from 15 months to more than 30 years, usually fatal within 1 year after diagnosis.
6. The most common form of classic CJD is believed to occur sporadically at a rate of approximately 1-1.5 cases per million population per year.

B. **PATIENT CARE:**

1. Normal social and patient contact and non-invasive procedures with TSE patients do not present a risk to healthcare workers, relatives, other patients or visitors.
2. Standard precautions should be used for all known or suspected cases.
3. It is very important that patients who are known or suspected to have prion disease be identified before any surgical procedure involving tissues that may be infectious.
4. Patients with TSEs must not donate organs, tissues, or blood components.
5. TSE is not known to be transmitted from mother to child during pregnancy or childbirth.
6. To prevent the transmission, it is important to consider: (1) the probability that an individual has or will develop TSE, (2) the level of infectivity in tissues or fluids, and (3) the nature or route of the exposure. Risk assessment and prevention of exposure through the use of personal protective equipment and disposable equipment are the best means to reduce any risk of transmission in the healthcare setting [Assignment of different organs and tissues to categories of high and low infectivity is chiefly based upon the frequency with which infectivity has been detectable, rather than upon quantitative assays of the level of infectivity, for which data are incomplete.]
7. Tissue infectivity:
   a. Highly infective tissues: Brain, spinal cord and eye
   b. Low infective tissues: Cerebral spinal fluid, lung, liver, kidney, spleen/lymph nodes, and placenta
   c. Non-ti~~-~~infectious:~~ve~~ Heart, skeletal muscle, peripheral nerve, adipose tissue, gingival tissue, intestines, adrenal gland, thyroid, prostate, testis~~)~~ or in blood, bodily secretions or excretions (**e.g.** urine, feces, saliva, mucous, semen, milk, tears, sweat, serous exudates).
8. Route of exposure:
   a. Very serious risk: CNS exposures (i.e. inoculation of the eye or CNS)
   b. Greater potential risk: Transcutaneous exposures: cut or puncture by a contaminated sharp instrument or contact with the mucus membrane of the eye
   c. Negligible risk: Cutaneous exposure of intact skin or mucous membranes, except those of the eye

C. **DIAGNOSTIC AND SURGICAL PROCEDURES**

1. All non-emergent brain biopsy procedures and neurosurgical and neuroophthalmology procedures are screened by the schedulers in Surgery Services or Interventional Radiology (See Appendix A). If the brain biopsy is for any reason other than tumor, or if TSE is suspected, notify the departments listed on the screening tool so that planning can be made for instrument handling, storage, cleaning and decontamination or disposal.
   a. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details. Clinical Laboratory stores 1 Molar sodium hydroxide.
   b. All known cases and cases that meet the case definition of suspect Transmissible Spongiform Encephalopathies will be performed with disposable instruments whenever possible.
   c. Procedures that are normally carried out at the bedside (e.g. lumbar puncture) may be performed at the bedside. Use a chux at the site to contain a potential spill of infective material.
   d. Alert the laboratory and clearly label all specimens. Place specimens in formalin as usual.
2. Dental Procedures: general infection control practices recommended by national dental associations are sufficient when treating TSE patients during procedures not involving neurovascular tissue. The following are precautions for major dental work:

a. Use single-use items and equipment e.g. needles and anesthetic cartridges.
b. Re-usable dental broaches and burrs that may have become contaminated with neurovascular tissue should be destroyed after use by incineration or decontaminated by a method listed on Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details.
c. Schedule procedures involving neurovascular tissue at end of day to permit more extensive cleaning and decontamination.

3. If reusable instrumentation must be used keep instruments and other devices moist between the time of exposure to infectious materials and subsequent decontamination and cleaning. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7, 8, and 9 for details.
   a. Remove bio-burden from reusable instruments while wearing a face shield or goggles and surgical mask and double glove. Instruments are then placed in a flash pan for processing as close as possible to the room where the procedure was performed. Autoclave for 18 minutes at 134°C.
   b. If the procedure was performed in another department (for example a brain biopsy in the CT scan) call Sterile Processing Department for assistance with autoclaving.
   c. After autoclaving place instruments in a robust, leak-proof container labeled "Incinerate Only". This box will be placed and remain in a designated locked area.
      i. If the laboratory result is negative, all items can be returned to the decontamination area and reprocesses as normal.
      ii. If the laboratory result confirms a Transmissible Spongiform Encephalopathy, the instruments will be sent out for incineration.
4. See unit specific policies for safety in the Clinical Laboratory.
5. Occupational exposure
   a. There have been no confirmed cases of occupational transmission of TSE to humans. Report any occupational exposure to blood, body fluids, or other potentially infectious materials to your supervisor and go to Emergency Room for assistance.

D. RELATED DOCUMENT(S):

1. Controlling TSE Agent Transmission in the Hospital
2. Employee Health & Wellness: Injury Illness Prevention Program
3. Infection Control Policy: Standard and Transmission Based Precautions
4. Infection Control Policy: Bloodborne Exposure Control Plan
5. Instrument Handling Algorithm
6. Laboratory Microbiology Policy: Tissues Handling Protocol
7. Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

E. REFERENCE(S):

1. Brown, P., Wolff, A., Gajdusek, D.C. (1990) A simple and effective method for inactivating virus infectivity in formalin-fixed tissue samples from patients with CJD. Neurology, 40: 887-890 **(Reviewed 10/23)**
2. Karasin, M. (2014, October). Special Needs Populations: Perioperative Care of the Patient with Creutzfeldt-Jakob Disease. Vol 100, No 4. (Reviewed **10**8/23)
3. Kavanagh, B. (2014) Creutzfeldt-Jakob disease and other Prion Diseases. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 73:1-14.(Reviewed **10**8/23)
4. Rutula, W., and Weber, D. (2010, February). SHEA Guideline: Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments. *Infection Control and Hospital Epidemiology*, Vol 31, No.2, 107-117. (Reviewed **10**8/23)
5. Steelman, V.M. (1994) Creutzfeld-Jakob Disease: recommendations for infection control. American Journal of Infection Control, 22(5): 312-318. **(Reviewed 10/23)**
6. www.who.int/emc WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies. (1999) **(Reviewed 10/23)**
7. ANSI/AAMI ST79:2017 page 124 C.2 (Reviewed **10**8/23)

Diagnosis	Procedures	Method and product/devices	Comments
Sporadic CJD; suspected TSE; at risk for CJD asymptomatic; (hormone recipient, dura mater transplant, familial CJD in a first degree relative).	1. Noninvasive procedures 2. Care after death, no postmortem performed 3. Employee sharps injury	1. Use standard cleaning, regular laundering, and routine waste handling. 2. Gently encourage site to bleed, wash with warm soapy water, rinse, and cover with a waterproof bandage.	1. There is no epidemiological evidence that normal contact presents a risk to health care providers. Procedures involving high-risk tissue or fluid, e.g., brain, spinal cord, pituitary, dura mater, retina, and cornea, require use of disposal aprons/gowns, gloves and single-use instruments/equipment. See next section. 2. Refer to special handling of tissue and special handling of the body after pathology procedures and postmortem. 3. Document all incidents. Maintain all files in the Employee Health dept.

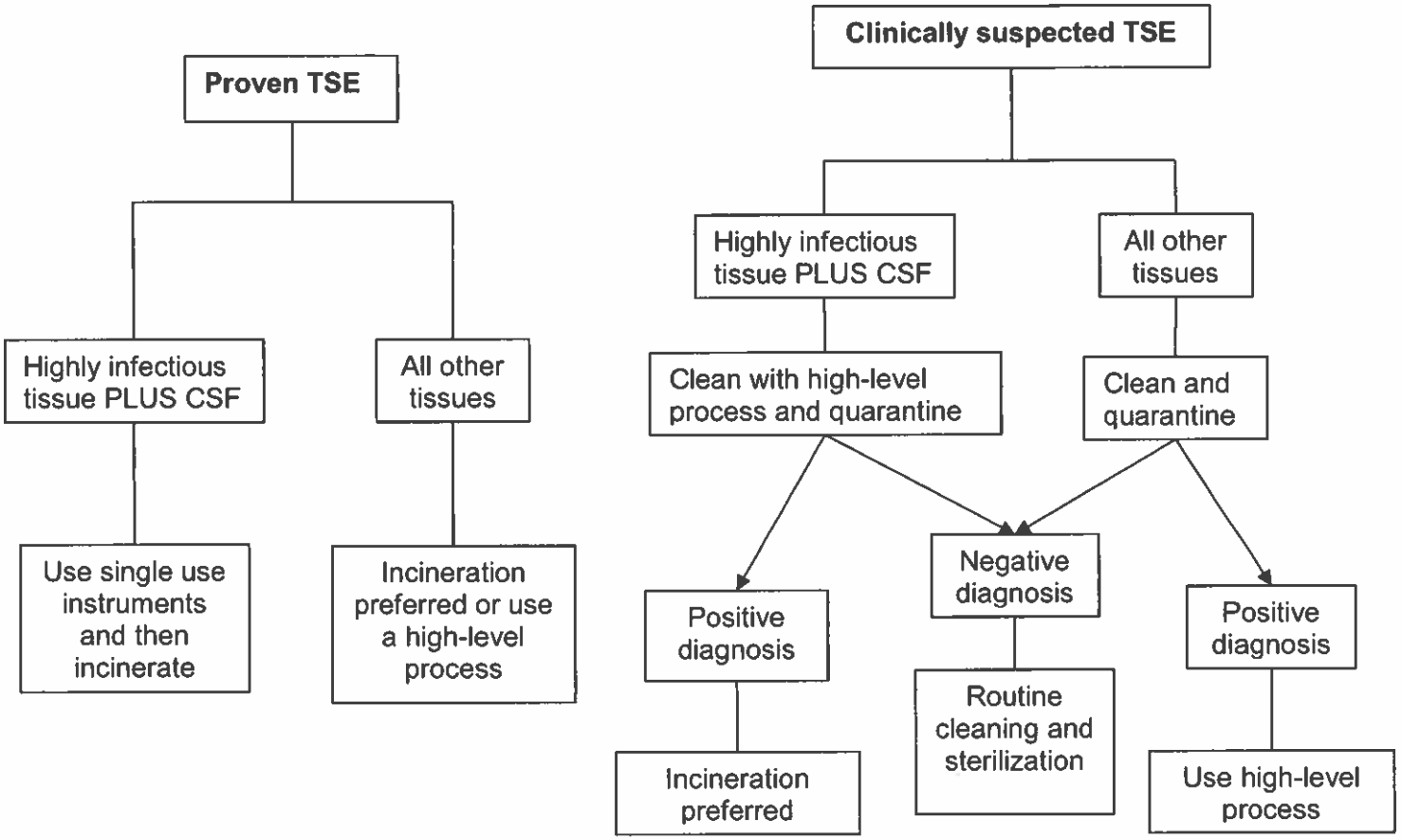
Diagnosis	Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)	Other nondisposable equipment		
Known TSE	• Where possible, avoid performing OR procedure. • If procedure must take place, book case at the end of the day. • The surgeon is to alert Surgery or Interventional Radiology when scheduling procedures. Schedulers are to notify the departments listed on the Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool. • Use dedicated sterile equipment or equipment nearing "end-of-life use" where possible. • Use disposable OR packs, gowns, drapes. • Use nonelectrical (mechanical)	• Cover nondisposable power equipment that must be used with plastic drapes. • Avoid touching surfaces with gloves, which have been in contact with brain, spinal cord and adjacent tissue. If in doubt, change gloves. • Keep the least amount of	Steps, OR Room: 1. Use damp cloth/sponge, superficial cleaning method 2 N NaOH undiluted for surfaces in the OR. 2. At end of case, place cleaning cloths in an "Incinerate Only" box. 3. Chemical disinfection - 2 N NaOH undiluted, disassembled equipment, completely submerged, or continuously wet for 60 min. Rinse in water and wipe dry.	• Consult with Sterile Processing Department (SPD) for supply and use of equipment nearing end-of-life use. (NaOH is highly corrosive). • Cases booked at the end of the day allow for surface decontamination of "touch surfaces" at end of the case with noxious agents (2 N NaOH undiluted for one hour and rinsed with water, non-critical patient care items and surfaces). • 2.5% sodium hypochlorite has been inconsistent in

	hand saws/drills. • Incinerate disposable supplies when procedure is complete. Suction wastewater and treat container with Premicide prior to placing in "Incinerate Only" box. 1. During procedure, use a damp cloth OR sponge-superficial wiping method to keep items clear of debris. Avoid excess handling of instruments. 2. At the end of the procedure, place all disposables in an "Incinerate Only" box and call the waste management vendor for disposal. Do not put any instruments from this case in contact with reusable containers.	equipment in the room. • Completely isolate/drape anesthetic/respiratory equipment near the patient's head to prevent accidental splatter or contamination of the equipment.	4. Confine and contain all effluent for incineration. Treat with Premicide to solidify waste for ease of handling 5. Manual clean instruments in OR area while wearing full face shield or mask and goggles. 6. Steam autoclave reusable items for 18 min. at 134 C; use an open container in a prevaccum sterilizer. 6. Place in an "Incinerate Only" box and transport to SPD for quarantine in the in a designated locked area.	killing the scrapie agent. • Tissue dried on instruments, which have not been inactivated first by NaOH, may have a protective effect on the TSE agent and render the autoclave process ineffective. Keep instruments moist until decontamination occurs.
Diagnosis	**Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)**	**Other procedures, equipment, potential risk**		**Comments**
Suspected TSE	Follow steps as above. SPD 1. Quarantine autoclaved reusable equipment until the diagnosis is finalized. • If confirmed positive, incinerate equipment. • If negative, follow regular cleaning in a washer disinfector, then routine sterilization.	Follow steps as above.		See comments above.
At risk for TSE asymptomatic (hormone recipient, dura mater, corneal transplant,	• Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period). Use disposable instruments wherever possible and follow steps as above.	Follow standard cleaning and sterilization.		• Regular cleaning and disinfection procedures with a hospital grade disinfectant in a basin (contact time according to label recommendation).

familial CJD in a first-degree relative.			• the incubation period for TSE is long. • Asmptomatic patients have very low infectivity. • Upgraded neurosurgical procedure equipment sterilization cycles will provide a margin of safety in the very rare event a TSE diagnosed case is found.
Diagnosis	**Lumbar puncture/biopsies**	**Specimen handling**	**Comments**
Known TSE **Suspected TSE** **At risk for TSE asymptomatic**	• Notify Infection Control • Only trained staff aware of TSE hazards should perform these procedures. • Perform procedures in an OR environment whenever possible. • Use disposable, single-use equipment where possible. • Incinerate packs, gowns, barrier drapes after use. • Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period) use disposable instruments wherever possible or use the NaOH decontamination process (see above procedure for suspected TSE). • Regular cleaning and sterilization	• It is prudent to refer to a specialist neuropathology lab center for brain and tissue biopsy material. • Containment is level 3 for central nervous system (CNS) samples. See department specific P&P. • Other clinical specimens are handled as per standard routine infection control precautions. • Tissue may still be **infectious after fixation**~~infective if fixed~~ in ~~formaldehyde~~ **formalin** and **formic acid**~~then c steam sterilized~~. • Other clinical specimens are handled as per standard routine infection control precautions. Other clinical specimens are handled as per standard routine infection control precautions.	• Routine disinfection for all non-contaminated surfaces. • Cases booked at the end of the day allow for decontamination of brain tissue contaminated surfaces with a solution of 2 N NaOH undiluted for one hour and rinsed with water, non critical patient care items and surfaces. Pay close attention to technique to avoid contamination and decrease the need for additional use of NaOH. • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent.

Instrument Handling Algorithm

Decontamination and disposition of instruments and equipment used with confirmed or suspected Transmissible spongiform encephalopathies (TSEs) patients.



Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

This information is required when scheduling any patient for non-emergent craniotomy or brain biopsy to identify potential Creutzfeldt-Jakob Disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstemenn-Straussler-Scheinder Syndrome (GSS), Kuru, or Fatal Insomnia

	Circle One	
1. Does the patient present with symptoms of TSE (rapidly progressive dementia, cerebella symptoms, spasticity or hyper-reflexia, EEG with periodic sharp-wave complexes, rapid cerebral atrophy on CT scan)?	Yes	No
2. Does the patient have a family history of CJD or CJD-like fatal illness?	Yes	No
3. Is the patient being scheduled for craniotomy or brain biopsy when diagnosis is unknown or uncertain (no specific lesion identified by imaging procedures)?	Yes	No
4. Is the biopsy for the diagnosis of dementia or encephalitis?	Yes	No

Patient Name_____ Today's Date_____

Surgeon providing the screening information_____

Office personnel providing the screening information_____

Print name of scheduler taking the Information_____

A "No" answer may be scheduled as usual.

A "Yes" answer to one of these questions means the patient meets the case definition of suspect Transmissible Spongiform Encephalopathies. Call the following services below to report and reference the policy in the Infection Control Manual, Transmissible Spongiform Encephalopathies.

Service	Phone Number	Message left	Spoke with (name of person) and Comments
Neuro-Speciality Coordinator	5400		
Environmental Services	7295		
SPD Ops Manager	7338		
Histology Supervisor	7914		
Infection Control	7410 or 5696		
Pharmacy	3012		

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**02/90**	**SUBJECT:**	**Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds**
REVISION DATE:	**01/03, 03/09, 11/10, 01/11, 07/17, 04/19, 02/23**	**POLICY NUMBER:**	**8710 – 522**

Medical Staff Department Approval:	**~~04/21~~07/23**
Department of Emergency Medicine Approval:	**~~04/22~~09/23**
Credentials Committee Approval:	**~~07/22~~10/23**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Interdisciplinary Committee Approval:	**~~10/22~~10/23**
Medical Executive Committee Approval:	**~~01/23~~10/23**
Administration Approval:	**~~02/23~~12/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **PURPOSE:**
1. To define the various privileges for ultrasound in Emergency Medicine.
2. To outline the two pathways by which Emergency Physicians and Allied Health Professionals (AHP) may demonstrate competency and be granted privileges in Emergency Ultrasonography (EUS).

B. **CORE PRIVILEGES IN EMERGENCY ULTRASONOGRAPHY:**
1. Trauma
2. Pregnancy
3. Cardiac/Hemodynamic Assessment
4. Abdominal Aorta
5. Airway/Thoracic
6. Biliary
7. Urinary Tract
8. Deep Vein Thrombosis (DVT)
9. Soft-tissue/Musculoskeletal (MSK)
10. Ocular
11. Bowel

C. **PROCEDURAL GUIDANCE PRIVILEGES IN EMERGENCY ULTRASONOGRAPHY**
1. Procedural Guidance **for Central Line, Paracentesis, Thoracentesis**

~~C.~~**D. ADVANCED PRIVILEGES:**
1. Ultrasound guided deep nerve blocks

~~D.~~**E. CREDENTIALING PATHWAYS:**
1. In accordance with the 20~~0~~13 Model of Clinical Practice of Emergency Medicine as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American College of Emergency Physicians (ACEP) policy statement for emergency ultrasound guidelines, following pathways are recognized to demonstrate proficiency in emergency ultrasound.
   a. Physician Residency-Based Pathway for Core Privileges in EUS:
      i. Requires demonstration of completion of an ACGME- approved Emergency Medicine residency program on or after July 1, 2010

ii. OR a letter from a residency program confirming formal training in EUS

~~i.~~**iii.** OR proof of competency ~~vi a~~**via** Residency Case Log to include a minimum of 150 EUS cases

~~ii.~~**iv.** For Advanced Procedures, the letter from **a** Residency/**Fellowship** Program must also confirm formal training in the Advanced Procedures listed above, and/or a case log including a minimum of 20 cases in that category **within the last 2-years.**

b. Physician and Allied Health Professional Practice-based Pathway for Core Privileges in EUS:

i. This requires **BOTH** of the following:

1) Demonstration of completion of a formal course in -EUS covering the core applications with both didactics and practical hands-on sessions. **(at least 16-hours of ACEP Category 1 Credit).**

2) ~~Experiential training period during which the practitioner must perform~~**Proctoring of** a minimum of 20 cases in any combination of the Core Privileges.

a) During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.

b) The ~~review~~**proctoring** shall be conducted by emergency physicians already credentialed in EUS.

~~b.~~**c.** Physician and Allied Health Professional Practice-based Pathway for Procedural Emergency Ultrasonography:

i. Physicians who are already credentialed to perform a procedure without ultrasound do not require additional credentialing to perform that procedure under ultrasound guidance.

ii. Allied Health Professionals (and physicians who are not already credentialed to perform these procedures) must demonstrate competency by completion of a formal course in basic Emergency Utrasonography (as above) AND by ~~performing~~ **proctoring of** a minimum of 5 ~~supervised~~ ultrasound guided procedures in any combination of- central lines, paracentesis, or thoracentesis

~~3)~~**1)** During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic/procedural accuracy.

~~4)~~**2)** The proctoring shall be conducted by emergency physicians already credentialed in Emergency Ultrasonography.

~~c.~~**d.** Physician and Allied Health ~~Professional Practice Based~~**credentialing** Pathway for Advanced Procedures:

i. This requires ~~BOTH~~**EITHER** of the following:

1) **Proof of completion of Residency/Fellowship training in Advanced Procedures within the last 2-years via a letter from a Residency/Fellowship Program that confirms formal training in the Advanced Procedures listed above, and/or a case log including a minimum of 20 cases in that category**
OR

2) Demonstration of completion of a formal course in Emergency Ultrasonography covering the ~~Special~~ **Advanced** Procedures listed above
AND

~~1)~~**3)** ~~Experiential training period during which the practitioner must perform a minimum of~~ **Proctoring of** 5 ~~supervised~~ cases in any combination of the ~~Special~~ **Advanced** Privileges.

~~a) During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.~~

~~b)~~**a)** The ~~review~~**proctoring** shall be conducted by emergency

physicians already credentialed in ~~ultrasound guided nerve blocks~~**the Advanced Procedures listed above**.

~~B.~~**F. ~~PROCTORING~~:**

~~1. Proctoring is not required for physicians:~~

~~i.~~**2.** ~~Who meet the Residency~~ **or Fellowship** ~~trained pathway requirements~~

~~ii.~~**3.** ~~Who use ultrasound guidance to perform procedures for which that physician is credentialed to perform in a "blinded" manner.~~

~~2. For all physicians and AHP who are not excluded from proctoring by the criteria above, the following proctoring will be required:~~

~~a. Core Privileges: 20 cases in any combination of the Core Privileges~~

~~b. Procedural Ultrasonography Proctoring Criteria: :~~

~~i. Three (3~~**Five (5)** ~~cases~~ **cases in any combination of** ~~of central line, and three (3) cases of either parcentesis or thoracentesis~~

~~c. Advanced Procedures: 5 cases in any combination of the advanced procedure category~~

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

1. Ultrasound Guidelines: Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine, ACEP Policy Statement, June 2016
2. Core Privileges for Physicians, Fourth Edition, 188-195.
~~2.~~**3.** ACGME 2013 Model of Clinical Practice of Emergency Medicine
~~3.~~**4.** American Medical Association House of Delegates Resolution 802 and policy 230.989.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/03

SUBJECT: Criteria for Pain Management Privileges

REVISION DATE~~(S)~~: 12/07, 06/18

POLICY NUMBER: 8710 – 541

Department Approval:	**~~02/17~~01/21**
Department of Anesthesiology Approval:	**~~05/18~~05/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/18~~10/23**
Administration Approval:	**12/23**
Professional Affairs Committee Approval:	**~~06/18~~ n/a**
Board of Directors Approval:	**06/18**

A. **PAIN MANAGEMENT DEFINITION:**

1. Pain management is the medical specialty concerned with the evaluation and treatment of patients suffering from acute or chronic pain.

B. **REQUIRED QUALIFICATIONS FOR PAIN MANAGEMENT PRIVILEGES:**

1. Initial Applicant: (applicants must meet all of the following)
   a. Medical Doctor (M.D.) or D.O.
   b. Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) (or equivalent) accredited training program in Anesthesiology, Diagnostic Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation.
   c. Successful completion of a minimum of twelve (12) months of formal training (or fellowship) that includes the diagnosis and management of patients with acute and chronic pain, interventional technology or completion of the equivalent of twenty-four (24) months of continuous, full time pain management practice.
   d. Certification in Anesthesiology, Radiology, Neurology, Neurosurgery or Physical Medicine and Rehabilitation or Pain Management by the American Board of Medical Specialties (ABMS), or actively involved in the examination process.
   e. Provide documentation of a minimum of twenty (20) pain management patients in the previous two (2) years.

C. **ELIGIBILITY:**

1. Eligibility for the granting of Pain Management Privileges shall be based on documented education, training and experience, demonstrated current professional competence and judgment, physical and mental health status and the ability to cooperate with others and to deliver care at a generally recognized level of professional quality.

D. **CONSULTATION:**

1. All practitioners are expected to exercise good judgment and request consultation when:
   a. Diagnosis and/or management remain in doubt for an undue period of time, especially in the presence of a life threatening illness;
   b. Complications or conditions arise which are outside their level of competence or scope of practice.
   c. Specialized treatments or procedures are contemplated with which they are not familiar.

E. **PAIN MANAGEMENT CORE PROCEDURES:**

1. Epidural Procedures: Translaminar and transforaminal Epidural injections (cervical, thoracic, Lumbar); Epidural blood patch
2. Joint Injections: Facets, Sacroiliac (SI) joint
3. Sympathetic Blocks
4. Chemo Denervation: Stellate Ganglion Block, Peripheral Nerve Block, Botox Injections, Intra-muscular Phenol Injections
5. Discograms
6. Initial Application: See required qualifications for Pain Management privileges. Current certification required for fluoroscopically-guided procedures.
7. Reappointment Criteria: Documentation of twenty (20) cases within the previous two (2) years and ongoing continuing medical education (CME) in pain management are required to maintain clinical competency.
8. Proctoring: Five (5) cases (of core pain management privileges) should be proctored, which should include at least three spinal (thoracic or lumbar) cases; with the exception of cervical cases, which would require an additional three cases be proctored.

F. **PAIN MANAGEMENT SPECIAL PROCEDURES:**

1. Radiofrequency Thermocoagulation Lesion Ablation (RFTC):
   a. Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in RFTC in Residency of fellowship, or provide documentation of a hands-on training course in RFTC.
   b. Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
   c. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at TCHD with the same privileges being proctored.
2. Intradiscal Electrothermal Annuloplasty:
   a. Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intradiscal Electrothermal Annuloplasty in residency or fellowship, or provide documentation of a hands-on training course in Intradiscal Electrothermal Annuloplasty.
   b. Reappointment Criteria: Satisfaction of the reappointment criteria for the Core Procedures will automatically satisfy reappointment criteria for this procedure.
   c. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at TCHD with the same privileges being proctored.
3. Implantables (Intrathecal or Epidural Infusion Pumps with Tunneled Catheter, Spinal Cord Stimulator):
   a. Initial Application: See required qualifications for Pain management privileges. Must provide documentation of training in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator in residency or fellowship, or provide documentation of a hands-on training course in Intrathecal or Epidural Infusion Pump with Tunneled Catheter and Spinal Cord Stimulator.
   b. Reappointment Criteria: Three (3) cases within the previous two (2) years with acceptable outcomes.
   c. Proctoring: Concurrent proctoring on a minimum of three (3) cases with satisfactory proctoring report is required for initial appointment. Proctoring shall be performed by a member of the medical staff at TCHD with the same privileges being proctored.
4. Cranial Nerve Blocks – All Types
   a. Initial Granting: Five (5) cases within two years of Residency
   b. Reappointment: One (1) per year (two (2) per reappointment cycle)
   c. Proctoring: Two (2) cranial nerve blocks – all types

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 10/05

SUBJECT: Physician/Podiatrist Surgical Assistant

REVISION DATE(~~S~~): 03/08, 11/14, 04/17, 04/20

POLICY NUMBER: 8710 – 536

Department Approval:	~~02/20~~06/23
Credentials Committee Approval:	~~03/20~~07/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~09/23
Administration Approval:	~~04/20~~12/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
   1. To provide credentialing criteria for non surgeon physicians and podiatrists in non-podiatric cases to act as surgical first assistants.

B. **SCOPE OF PRIVILEGES:**
   1. Provides aid in exposure, hemostasis, use of surgical instruments on tissues, and other technical functions to help the surgeon carry out a safe operation.

C. **CREDENTIALING CRITERIA:**
   1. Letter(s) of reference from individual responsible for formal training and/or a surgeon who is familiar with the physician's experience as a surgical first assistant; **and**
      a. Completion of a surgical residency from a program accredited by the Accreditation Council for Graduate Medical Education (ACGME); **or**
      b. Completion of a surgical rotation during internship training of at least (six weeks) in duration; **or**
      c. A licensed Doctor of Podiatric Medicine, licensed after 1984.

D. **PROCTORING:**
   1. A minimum of three (3) cases in which the physician acts as the surgical first assistant shall be proctored by the primary surgeon. There should be at least two (2) different primary surgeons.

E. **REAPPOINTMENT:**
   1. A minimum of three (3) cases as a surgical first assistant shall be performed per two-year reappointment cycle. Quality assurance mechanisms will be applied and considered in the reappointment process.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 10/03

SUBJECT: Requests for New Privileges/Technologies New to TCHD

REVISION DATE~~(S)~~: 03/08, 08/12, 04/17, 04/20

POLICY NUMBER: 8710 – 526

Medical Staff Department Approval:	~~02/20~~06/23
Credentials Committee Approval:	~~02/20~~07/23
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~09/23
Administration Approval:	~~04/20~~12/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **POLICY:**

1. The Tri-City Healthcare District (TCHD) Medical Staff shall review requests for new procedures/technologies.

B. **PURPOSE:**

1. To provide a mechanism to evaluate requests for new procedures/technologies, to determine if criteria must be developed, and whether the resources necessary to support the request are available.

C. **PROCEDURE:**

1. Practitioners requesting new procedures/technologies must submit a request in writing along with supporting documentation and proposed criteria to the Medical Staff Office.
2. Upon receipt of a new procedure/technology request, the Medical Staff Office shall evaluate to determine the following:
   a. Is the procedure/technology new to TCHD: https://www.nlm.nih.gov/services/ctconsent.html
      i. If no, refer to appropriate department/division rules and regulations for criteria.
      ii. If yes, submit request and supporting documentation to the appropriate Department/Division to determine if it is similar to an existing procedure. If there is a similar procedure/technology, are there additional qualifications?
         1) If no, add to the appropriate Rules and Regulations and process for approval. Upon Board approval, add the procedures to the appropriate privilege list.
         2) If yes, assess resource availability.
            a) Submit request to the appropriate department director to determine; if there is sufficient space, equipment, staffing, and financial resources either in place or available within the specified time frame to support each requested privilege.
            b) If resources are available, the Medical Staff Office shall contact the appropriate Division and/or Department to review the request and develop criteria in collaboration.
               i) If the request involves more than one Division and/or Department, the criteria should be outlined in policy format.
               ii) If the request involves a single Division and/or Department,

the criteria shall be outlined in the appropriate rules and regulations.

c) Develop criteria based on current standards. Resources to consider include, but are not limited to:
   i) Clinical White Papers
   ii) Clinical resources
   iii) Community standards.

d) Criteria shall address as applicable:
   i) Board certification or equivalent training
   ii) Procedure-specific certification/training
   iii) Documentation of Current Competency – i.e. case logs
   iv) Initial Criteria
   v) Proctoring Criteria
   vi) Reappointment Criteria.

e) If resources are not available, request shall be denied.
   i) Such denial is not considered practice specific and is not subject to procedural rights of the Medical Staff Bylaws.

3. Upon finalization of proposed criteria, the Medical Staff Office shall submit the proposed criteria to the appropriate Division and/or Department, and the clinical director (as applicable) for review.
4. Upon Division and/or Department approval, the request shall be forwarded to:
   a. Credentials Committee along with the appropriate Division/Department's recommendation, if the criteria involve one or more Divisions and/or Departments, then to the Medical Executive Committee (MEC).
   b. Medical Executive Committee (MEC) along with the appropriate Division/Department's recommendation, if the criteria involve a single Division and/or Department..
5. Favorable recommendations from the MEC shall be submitted to the Board of Directors for approval.
6. Upon approval, the criteria shall be incorporated into the appropriate privilege forms and made available to Medical Staff members.

D. **ONGOING EVALUATION**:
1. The Medical Staff works in collaboration with administration to consistently review the resources needed to perform the requested privileges.

E. **REFERENCES:**
1. Joint Commission Medical Staff Standards 2022~~17~~
2. The Compliance Guide to the Joint Commission Medical Staff Standards

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 01/80 **POLICY: Pharmacy and Therapeutics Committee**

REVISION DATE: 01/94, 01/97, 09/00, 02/03, 06/05, 07/06, 07/09, 01/12, 04/14, 07/18

Department Approval:	~~03/22~~09/23
Pharmacy & Therapeutics Committee Approval:	~~03/22~~09/23
Medical Executive Committee Approval:	~~05/22~~10/23
Administration Approval:	~~06/22~~12/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/22

A. **POLICY**:

1. The Pharmacy and Therapeutics **(P&T)** Committee exists as part of the hospital medical staff and is responsible for managing the formulary system. P&T ~~C~~committee members are appointed by medical staff to serve in an evaluative, educational, and advisory capacity to the medical staff and organizational administration in all matters pertaining to the use of medications (including investigational medications). The P&T ~~C~~committee is responsible for overseeing policies and procedures related to all aspects of medication use within an institution. The P&T ~~C~~committee is responsible to the medical staff as a whole, and its recommendations are subject to approval by the organized medical staff as well as the administrative approval process.
2. Other responsibilities of the P&T ~~C~~committee include medication- use evaluation (MUE), adverse-drug-event monitoring and reporting, medication-error prevention, and development of clinical care plans and guidelines.

B. **ORGANIZATION:** As defined in Section 10.18-1 of the Medical Staff Bylaws.

C. **FUNCTIONS AND SCOPE**: As defined in Section 10.18-2 of the Medical Staff Bylaws.

D. **CONFLICT OF INTEREST:**

1. To assure decisions made by the Pharmacy and Therapeutics Committee are of the highest ethical quality and not influenced by any associations with outside sources with respect to an alternate agenda the following is required:
   a. Pharmacy and Therapeutics Committee members in order to serve are required to complete and sign a Conflict of Interest Disclosure Statement. ~~See Attachment 1: Conflict of Interest Disclosure Form below.~~
   b. Anyone who provides information or recommendations to the committee related to medication use is required to sign a Conflict of Interest Disclosure Statement.
   c. Any practitioner submitting a request for formulary revision is required to provide a Conflict of Interest Disclosure Statement. This statement may be included within the ~~Formulary Revision Request Form document. See Attachment 2.~~ Formulary Request Form. ~~See Attachment 1~~
   d. Conflict of Interest Disclosure Statement forms are submitted to the Pharmacy and Therapeutics Committee Chairperson or the Director of Pharmacy and are reviewed by the committee. Any actual or potential conflicts identified will attempt to be resolved. In the absence of resolution, the matter shall be in accordance with the Medical Staff Conflict of Interest Policy. Conflict of Interest Disclosure Statements are retained on file by the Director of Pharmacy Services.

e. Any member of the hospital committee who perceives a conflict of interest for himself/herself is required to take the following action:
   i. Declare the conflict of interest prior to discussions or debate
   ii. Refrain from voting on an issue in which the conflict of interest exists
   iii. Refrain from influencing other members' votes for an issue in which a conflict of interest exists

f. Any member that perceives or suspects another member of a potential conflict of interest is required to request tabling the discussion until the suspicions and conflicts are resolved.

B. RELATED DOCUMENT(S):

~~2.~~1. ~~**Attachment 1:**~~ **Formulary Request Form**

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { } **Deletion { }**

Date: **Requestor:**

Trade Name: **Generic Name:**

Dosage form(s):

Indication:

Efficacy:

Safety:

Propensity for medication error:

Abuse potential:

Sentinel event potential:

Black box warning:

Cost comparison with similar Formulary products:

Drug	**Cost**

Other considerations:

Recommendation:

Process/Plan to monitor Patient Responses:

References:

1.

Conflict of Interest Disclosure Statement (Please check all that apply)

Serving the public interest shall remain the primary focus of all hospital committee activities. Any circumstances that might potentially be viewed as a conflict of interest in serving the public must be identified.

- ☐ I am a consultant or have served on an advisory board for the company that makes/distributes this drug.
- ☐ I have research funded by the company that makes/distributes this drug.
- ☐ I own stock/stock options for the company that makes/distributes this drug.
- ☐ I am a speaker for the company that makes/distributes this drug.
- ☐ Other: _____
- ☐ None of the above

Submitted by (Signature) _____ Date: _____

Print Name: _____ Phone: _____

Tri City Medical Center Department of Pharmacy Services
Pharmacotherapy Utilization Form

☐ Non-formulary use

☐ Use outside of restriction

Condition being treated: _____

Drug Requested and dosage form: _____

Dosage: _____

Rationale for use (indicated why current TCMC formulary agents are inappropriate): _____

_____

Estimated duration of therapy: _____

Physician signature: _____ Print Name: _____

Service: _____ Pager Number: _____

_____

Pharmacy Use Only

Pharmacist Comments (with justification): _____

_____

☐ Approved ☐ Not Approved

☐ No need to order drug ☐ Please order drug supply

Action taken if not approved: _____

Pharmacist Signature: _____ Print Name: _____

Tri-City Medical Center	Surgical Services
PROCEDURE:	**DUODENOSCOPE SAMPLING FOR QUALITY CONTROL CULTURING**
Purpose:	To provide protocols for surveillance sampling and culturing of reprocessed duodenoscopes intended as a quality control measure of the adequacy of reprocessing. -Duodenoscope sampling is used to identify endoscopes with persistent contamination despite reprocessing. -The primary focus of this protocol is for the detection of organisms of concern, some of which have been associated with infectious outbreaks. -This protocol is not intended to be used during a suspected outbreak linked to inadequately reprocessed endoscopes, and results after following this protocol cannot be used to certify that an endoscope is sterile.- Culturing information may be used to identify systemic errors in reprocessing or damaged endoscopes and equipment. -This protocol is designed to identify most organisms of concern that could be present on a duodenoscope, and is not intended to culture all microbes that could potentially contaminate a flexible duodenoscope.
Supportive Data:	Microbial sampling and culturing of duodenoscopes involves sampling duodenoscope channels and the distal end of the duodenoscope (see Appendix B, "Duodenoscope Diagram"), followed by culturing those samples with the goal of detecting contamination that may be present on the duodenoscope after reprocessing. -Among all flexible endoscopes, duodenoscopes were selected for sampling because of the national reports of infections associated with this specific type of reprocessed endoscope.- Surveillance sampling and culturing is not a substitute for a comprehensive endoscope reprocessing program that includes, but is not limited to, complete adherence to professional guidelines and the manufacturer's reprocessing and maintenance recommendations.
Equipment:	See Appendix A
Issue Date:	08/20

A. **DEFINITIONS: (See diagram Appendix B)**

1. Biopsy port: -The entrance to the instrument channel on the endoscope. -The biopsy port is where accessory instruments (such as biopsy forceps or guidewires) are introduced into the endoscope.
2. Channels: -Duodenoscopes have multiple channels (long, narrow lumens) that have different functions during endoscopy. -For example, the instrument channel allows insertion of accessory instruments into the endoscope for biopsy or therapeutic reason.
3. Control Handle:- The location of the endoscope that is handled by the physician during an endoscopy procedure. -The control handle includes the button and knobs for control of the optics, movement of the distal portion of the endoscope, air insufflation and lens washing.
4. Distal End: -The distal end includes the terminal end of the insertion tube that is inserted into the patient during the endoscopic procedure.- This location of the duodenoscope also includes the elevator lever and elevator recess.
5. Elevator Lever:- Also known as an elevator, the elevator lever is located at the distal end of the duodenoscope.- It is a small piece, usually metal, that can pivot. -When raised, the elevator lever changes the angles of accessory instruments exiting the instrument channel at the distal end, up to a nearly 90 degree angle.
6. Elevator Recess:- The recessed area surrounding the elevator lever.- This area has numerous small crevices, making the elevator recess particularly challenging to clean.
7. Instrument Channel: -The channel spanning from the biopsy port to the distal end. -This channel is used to insert instruments into the endoscope for use during endoscopy. -The instrument channel forms a part of the suction channel, which extends from the distal end to the proximal end of the endoscope.

Department Review	Operating Room Committee	Department of Pathology	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/20, **08/23**	03/20, **08/23**	04/20, **09/23**	05/20, **09/23**	n/a	06/20, **10/23**	07/20, **12/23**	n/a	08/20

8. Lowered Position: -The position for the elevator lever being parallel to or within the elevator recess relative to the distal end of the duodenoscope.
9. Raised Position: -The position of the elevator lever such that it is perpendicular to the distal end of the duodenoscope.

B. **POLICY**

1. Each duodenoscope shall be sampled and cultured quarterly.
2. The sampling protocol is limited to obtaining samples from elevator recess and instrument channel of clinically used and reprocessed duodenoscopes for the purposes of surveillance.
3. Two staff members are required for duodenoscope sampling: one staff member (the sampler) maintains aseptic handling and conducts brushing steps, while the second staff member (the facilitator) opens packages and handles the unsampled portions of the endoscope.
4. Three samples should be collected and combined: distal cap seams (by swab method), instrument channel (by flush, brush, flush method) and elevator recess (by flushing and brushing 3method).
5. Collection of duodenoscope samples may generate aerosols.- Appropriate personal protective equipment (PPE) must be worn and fresh PPE must be utilized with each duodenoscope sampled.
6. The duodenoscope may be used for patient care while culture results are pending.
7. Microbiology/Infection Preventionist shall notify the Director of Surgical Services of culture results and appropriate follow-up action shall be taken.
    a. Negative culture results: no action necessary.
    b. Positive culture results (i.e., results exceed the pre-determined microbial limit):
        i. If duodenoscope culture results exceed the pre-determined microbial limit, the duodenoscope shall be quarantined and reprocessed.- A new sample shall be collected from the duodenoscope post-reprocessing and the duodenoscope shall remain quarantined until results of the re-test are obtained.
        ii. Reprocessing practices shall be reviewed and appropriate staff shall be re-educated.
        iii. Sampling and culturing procedures shall be reviewed and appropriate staff shall be re-educated.
8. Duodenoscope sampling records, including culture results, shall be maintained by Infection Prevention for 7 years, then destroyed.

C. **PROCEDURE:**

1. Clean and disinfect the work surface **area** that will be used for duodenoscope sampling.
2. Perform hand hygiene.
3. Label the sterile sample cup with duodenoscope identifying information, including:
    a. Duodenoscope model and serial number (e.g., TJFQ180V, #2619131)
    b. Channels/sites sampled (e.g., Distal cap seams, Instrument Channel, Elevator Recess)
    c. Date
    d. Time
    e. Cerner code of individual collecting the sample
4. Perform hand hygiene.
5. Sampler: Don PPE, including:
    a. Fluid-resistant sterile gown
    b. Fluid-resistant face mask and eye protection
    c. Sterile gloves
    d. Bouffant cap for hair
6. Facilitator: Don PPE, including:
    a. Fluid-resistant face mask and eye protection
    b. Bouffant cap for hair
7. Facilitator: Using aseptic technique, cover work surface with a sterile drape.- Place duodenoscope on the sterile drape, taking care to avoid contact with the elevator recess.

8. Sampler:- Before sampling the duodenoscope, perform a visual inspection of the distal end for any debris or other concerns using 10x magnification.
   a. If visual debris is present, continue with sample collection, but note the visible debris on the Microbiology requisition. -Send the debris for culture (process separately from collected surveillance sample).
   b. Notify the Director of Surgical Services of the duodenoscope reprocessing breach.
   c. The duodenoscope shall be cleaned, inspected, and high level disinfected after sampling.
9. Sample the distal cap seams:
   a. Facilitator:
      i. Open a sterile alcohol wipe package.
   b. Sampler:
      i. Remove sterile alcohol wipe from package.
      ii. Wipe exterior of distal end with alcohol wipe.- Ensure the elevator recess and the seams near the elevator recess are not exposed to the alcohol during wiping.
      iii. Wipe away from the elevator recess, taking care to avoid the elevator lever, recess, and the seams between the distal cap and distal end.- Allow the alcohol to dry. Refer to Appendix B "Distal Cap Seams Sampling Method".
   c. Facilitator:
      i. Open the sterile swab package.
      ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has moistened the swab in the sterile water).
   d. Sampler:
      i. Remove the sterile swab from the package.
      ii. Moisten the sterile swab in sterile water.
      iii. Swab along the seam between the distal cap and the distal end.- Refer to Appendix B "Distal Cap Seams Sampling Method".
   e. Facilitator:
      i. Open the sample collection container and hold the container to allow sampler to break off the tip of the sterile swab into the sample collection container.- Sterile scissors may be used to cut off the swab head into the sample collection container.
      ii. Close the sample collection container.
10. Sample the elevator recess:
   a. Facilitator:
      i. Aseptically open the package for the sterile 3mL syringe.
      ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has withdrawn sterile water).
   b. Sampler:
      i. Remove the sterile 3mL syringe from the package.
      ii. Fill the sterile 3mL syringe with 1mL of fresh, sterile water.
   c. Facilitator:
      i. Lower the elevator lever.
   d. Sampler:
      i. While holding the distal end so that it is parallel to or lying flat on the sterile drape or pad, apply 1mL of sterile water into the elevator recess with the sterile 3mL syringe.
      ii. Use the same syringe to draw the fluid up and down five times.
      iii. Suction the fluid into the syringe while the facilitator raises the elevator lever.
      iv. Repeat this step by applying fluid into the recess and drawing the fluid up and down five times.
   e. Facilitator:
      i. Open the sample collection container (close the container after the sampler has added the sample).
   f. Sampler:

i. Use the same syringe to remove fluid from the elevator recess and transfer the fluid to the sample collection container.

g. Facilitator:
   i. Open the package for the sterile elevator cleaning brush.
   ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has moistened the brush in sterile water).

h. Sampler:
   i. Remove the sterile elevator cleaning brush from the packaging and moisten in fresh, sterile water.
   ii. Brush the elevator recess while the facilitator raises and lowers the elevator.
   iii. Place the brush head over the sampling container.
   iv. Use sterile scissors to cut the off the entire head of the bristled portion of the brush and drop it into the sample container.

i. Sampler and facilitator:
   i. With a new sterile 3mL syringe, repeat steps C.10.a through C.10.f.

11. Sample the instrument channel:
   a. Facilitator:
      i. Aseptically open the packages for two 30mL syringes.
      ii. Open the sterile water container.
   b. Sampler:
      i. Remove each 30mL syringe from the packaging.
      ii. Fill each syringe with 20mL sterile water.
      iii. Place the syringes on the sterile drape.
   c. Facilitator:
      i. Don fresh sterile gloves.
      ii. Elevate the control handle of the duodenoscope so the duodenoscope is nearly vertical.
   d. Sampler:
      i. Hand a syringe to the facilitator.
      ii. Hold the distal end of the duodenoscope over the sample collection cup (to collect water flushed through the instrument channel by the facilitator).
   e. Facilitator:
      i. Flush the instrument channel (via the biopsy port) with 20mL sterile water, which sampler will collect in the sample collection container.
      ii. Fill the syringe with air and flush air into the instrument channel. -Collect any residual fluid in the sample collection container.
   f. Sampler:
      i. After air has been flushed into the channel, cap the sample collection container and place it on the sterile drape.
   g. Facilitator:
      i. Place the duodenoscope on the sterile drape.
      ii. Open the sterile instrument channel brush package and sterile scissor package.
   h. Sampler:
      i. Remove the sterile instrument channel brush from the packaging.
   i. Facilitator:
      i. Hold the duodenoscope vertically.
   j. Sampler:
      i. Insert the sterile instrument channel brush into the biopsy port.
      ii. Once the brush has been inserted about 3 inches, transfer the brush handle to the facilitator.
      iii. Hold the collection container at the distal end to capture any fluid that exits the channel with the brush, making sure not to touch the distal end.
   k. Facilitator:
      i. Continue to push the brush through the instrument channel.

l. Sampler:
   i. After the brush head exits the distal tip, use sterile scissors to cut the entire bristled portion of the brush and places it into the sample collection container.

m. Facilitator:
   i. Pull the remaining portion of the brush out of the duodenoscope from the biopsy port.
      1) Do not attempt to force the brush handle out through the distal end of the duodenoscope.
   ii. Discard the brush handle in the trash.

n. Sampler and facilitator:
   i. Repeat steps C.11.c through C.11.f.

12. Complete a Microbiology Requisition form for each sample collected, including:
    a. Duodenoscope model and serial number (e.g., TJFQ180V, #2619131)
    b. Channels/sites sampled (e.g., Distal cap seams,- Instrument Channel, -Elevator Recess)
    c. Reason for collecting the sample (i.e., Surveillance Monitoring)
    d. Date
    e. Time
    f. Cerner code of individual collecting the sample
13. Send the collected sample(s) and accompanying Microbiology Requisition(s) to Microbiology department immediately.
14. Clean, high level disinfect, dry and return the duodenoscope to storage per manufacturer's instructions for use (IFU) and Patient Care Services Procedure: High Level Disinfection.

D. **REFERENCES:**

1. Duodenoscope Surveillance Sampling & Culturing: Reducing the Risks of Infection.- Department of Health and Human Services Collaboration (2018).

APPENDIX A

EQUIPMENT

a. Fluid-resistant sterile gown
b. Fluid-resistant face mask and eye protection
c. Sterile gloves
d. Bouffant cap for hair
e. Fluid-resistant sterile drape
f. 10x magnifying glass
g. Sterile specimen cups
h. Specimen labels
i. Sterile water (approximately 50mL)
j. Sterile alcohol wipes
k. Sterile cotton-tip swabs
l. 3mL syringes x 4
m. Sterile brush for elevator recess (i.e., Olympus Single Use Combination Cleaning Brush Model #BW-412T, sterilized according to manufacturer's instructions for use)
n. Sterile scissors
o. Sterile brush for instrument channel (i.e., Olympus Single Use Combination Cleaning Brush Model #BW-412T, sterilized according to manufacturer's instructions for use)
p. Large Back Table

APPENDIX B

DUODENOSCOPE DIAGRAM

Figure 1: Duodenoscope diagram

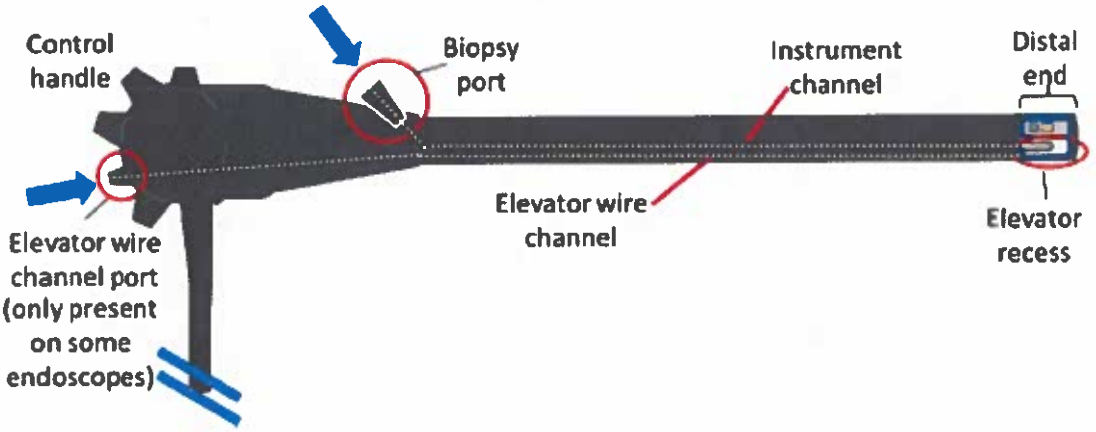
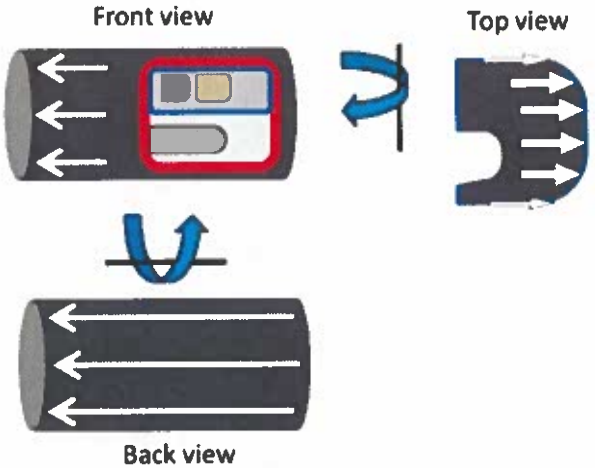


Image retrieved from Department of Health and Human Services Collaboration:
Duodenoscope Surveillance Sampling & Culturing, 2018.

DISTAL CAP SEAMS SAMPLING METHOD



White arrows represent location and direction of alcohol wiping of the exterior of the distal end.
Red box identifies the location of seams to swab for sampling.
Image retrieved from Department of Health and Human Services Collaboration:
Duodenoscope Surveillance Sampling & Culturing, 2018.

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
October 26 – 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 October 26, 2023.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director 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
Jeremy Raimo, Chief Operations Officer
Donald Dawkins, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Mark Albright, Chief Information Officer
Aaron Byzak, Chief Strategy Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, 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 made opening comments regarding the public's participation in today's meeting and the procedure to be followed for those wishing to speak. The public was also invited to participate via Zoom and were asked to indicate their desire to speak via the "chat" feature.

5. a) Introduction by Steve Hollis, District Consultant

Steve Hollis, District Consultant

Board Chairperson Younger introduced Steve Hollis, District Consultant. Mr. Hollis set the stage for today's presentations by Sharp and UC San Diego Healthcare. He stated the medical center is under intense financial pressure right now and had to curtail a very important service that our community held fondly, largely in response to those financial pressures. He explained that the Board directed management to seek proposals from potential partners that might help them secure the future of the hospital and render it sustainable into the future.

Mr. Hollis stated, of the three San Diego systems that were considered potential partners at the outset, two have submitted proposals for the Board's consideration today – Sharp Healthcare and UC San Diego Health. Each entity will be presenting their own proposals, however he commented on the structures, including that of a Joint Powers Agreement that will be presented in seeking a new steward for the hospital. Mr. Hollis noted the proposal to be presented by Sharp Healthcare is significantly different from the one distributed and posted on our website, as Sharp sought approval this week to submit an amended proposal which was agreed upon by the district.

b) Presentation of Affiliation Proposal from Sharp HealthCare

Chris Howard, Chief Executive Officer for Sharp Healthcare presented Sharp's Affiliation proposal, a copy of which is attached to these minutes for the record. Mr. Howard highlighted the changes that were made in the amended proposal. At the conclusion of Mr. Howard's presentation, Board members asked questions that were answered by Mr. Howard.

c) Presentation of Affiliation Proposal from UC San Diego Health

Patty Maysent, Chief Executive Officer for UC San Diego Health, along with Pradeep K. Khosla, Chancellor, UC San Diego Health presented UC San Diego Health's Joint Powers Agreement Proposal, a copy of which is attached to these minutes for the record. The Chancellor predicted, with great certainty, the unanimous approval by the Regents of this proposal. At the conclusion of the presentation, Board members asked questions that were answered by Ms. Maysent and others from her management team.

d) Possible additional comments by Steve Hollis, District Consultant

Mr. Howard did not have any additional comments.

e) Public Comments -

Director Younger recognized the following individuals who spoke in support of both Sharp Healthcare and UC San Diego Health:

Selena Juarez Alvarado; Ally Murray; Angela Morris; Linda Slater; Esther Sanchez; Janyce Ally; Julie Dye; Luke Roy; Paul Kim, M.D.; Donna Cleary; Jennifer Roro; Mali Woods; Sunil Jeswani, M.D.; Brenda Russell; Risa Demetrio; Rio Cohen; Sabareesh Natarajan, M.D. Beatriz Palmer; Ramin Raiszadeh, M.D.;

J. E. Wynne; Emily Bond; Fernando Sanudo; Paul Larimore; Brianna Hansen; Angela Korver; and Doris Turner – (attorney Scott called for point of order and requested Ms. Turner hold her comments to item #12).

Director Younger stated she has also received written public comments that will be made a part of the record.

f) Board Discussion –

Board members, along with Dr. Gene Ma, CEO discussed the proposals from the two entities, Sharp Healthcare and UC San Diego Health. All Board members stated they were extremely impressed with both proposals from two nationally acclaimed leaders in healthcare. They discussed the differences and timing of each proposal.

At Chairperson Younger's request, Dr. Ma provided his opinion and recommendation, stating after much deliberation, he was left to conclude, without hesitation, that UC San Diego Health is best positioned to ensure the viability and long-term sustainability of Tri-City Healthcare District.

g) Ad Hoc Recommendation –

Director Younger stated that members of the Ad Hoc Committee have met with representatives from multiple health systems over the last few months and have selected Sharp Healthcare and UC San Diego Health proposals to bring forth to the Board for consideration. Director Younger further stated, that after careful review of the two proposals, and considering the commitments both proposals provide, the Ad Hoc Committee believes that it would be in the best interests of the communities, residents and patients served by the District to direct staff and consultants to move forward with the proposal from UC San Diego Health, complete the necessary due diligence, and bring back an agreement based on their proposal for consideration of the full Board.

It was moved by Director Chaya to direct staff and consultants to move forward with the proposal from UC San Diego Health, complete the necessary due diligence, and bring back an agreement based on their proposal for consideration of the full board. 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**

Director Younger called for a brief 10-minute recess.

At 7:30 p.m. the Board reconvened with all board members present.

6. Old Business – None

9. Chief of Staff –

a) Consideration of the October 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on October 23, 2023.

b) Consideration of Clinical Privilege Request Form - Pulmonary

Dr. Henry Showah, Chief of Staff presented the October 2023 Credentialing Actions and Reappointments Involving the Medical Staff, as well as the Clinical Privilege Request Form – Pulmonary. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Chavez to approve the October 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Clinical Privilege Request Form as recommended by the Medical Executive Committee on October 23, 2023. Director Chaya 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**

Dr. Showah stated he was exited excited about the decision made by the Board to partner with UC San Diego Health.

10. Consideration of Consent Calendar

It was moved by Director Chavez to approve the Consent Calendar. Director Chaya 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

Director Younger recognized Brenda Russell who spoke on behalf of Doris Turner regarding the use of LVNs in the Emergency Room.

13. Comments by Chief Executive Officer

Dr. Ma stated with the vision of Chancellor Khosla and the transformational leadership of Patty Maysent, Tri-City will fulfill its vision as the healthcare system of choice as a world-class campus in a community setting. Dr. Ma stated he is truly grateful for each Board member and their courage and commitment. He stated "he has never been prouder to be a part of this hospital, which will once and for all fulfill its promise to the community, for the good of the constituents of this region who are the true beneficiaries of your sacrifices and service". Dr. Ma asked invited everyone to stand and acknowledge the thankless devotion of the seven Board members of the Tri-City Healthcare District Board of Directors.

14. Board Communications

Director Chavez recognized the Ad Hoc Committee and stated he appreciates the leadership the committee provided during this process.

Director Coulter echoed Director Chavez's comments.

Director Mizell stated he is very happy for this community and hospital.

Director Sanchez commented on the two great proposals presented today and stated she was proud to have been part of this process.

Director Gleason commented that she has never been happier or prouder to be part of this hospital and community.

Director Chaya recognized the C-Suite for their efforts throughout this process.

Chairperson Younger also recognized the C-Suite and gave a special thanks to Board Counsel, Jeff Scott for his work during this very challenging time.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 7:38 p.m.

_____
Tracy M. Younger, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

SHARP

Tri-City Healthcare District

Presentation of Affiliation Proposal

SHARP WILL TRANSFORM THE HEALTH CARE EXPERIENCE

Sharp's Vision

Sharp will ***transform the health care experience*** and be recognized as:

- ***The best place to work,***
- ***The best place to practice medicine, and***
- ***The best place to receive care.***

Sharp will be known as an excellent community citizen embodying an organization of people working together to do the right thing every day to improve the health and wellbeing of those we serve. ***Sharp will become the best health system in the universe.***

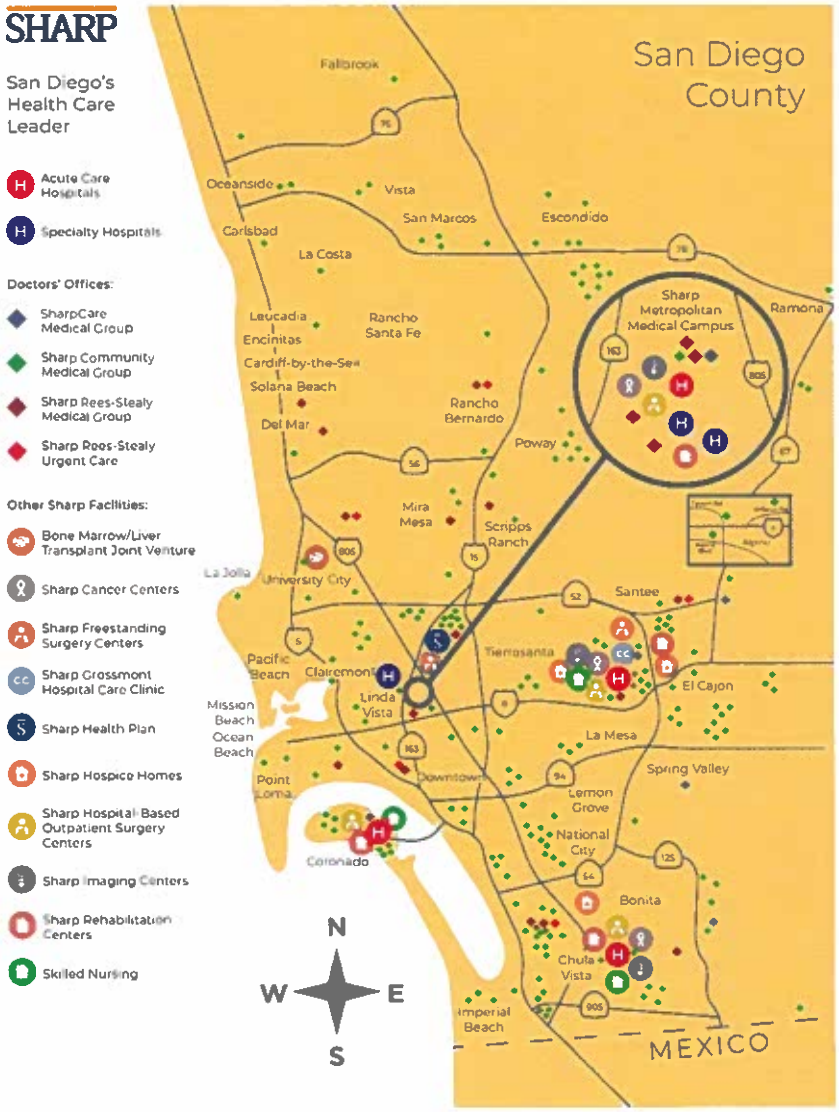
Sharp's Defining Characteristics

A **San Diego based integrated delivery system** grounded in…

The Sharp Experience that serves as…

San Diego's health care leader with…

Experience **successfully working with healthcare districts**


SHARP
San Diego's Health Care Leader
Acute Care Hospitals
Specialty Hospitals
Doctors' Offices:
SharpCare Medical Group
Sharp Community Medical Group
Sharp Rees-Stealy Medical Group
Sharp Rees-Stealy Urgent Care
Other Sharp Facilities:
Bone Marrow/Liver Transplant Joint Venture
Sharp Cancer Centers
Sharp Freestanding Surgery Centers
Sharp Grossmont Hospital Care Clinic
Sharp Health Plan
Sharp Hospice Homes
Sharp Hospital-Based Outpatient Surgery Centers
Sharp Imaging Centers
Sharp Rehabilitation Centers
Skilled Nursing
San Diego County
Fallbrook
Oceanside
Vista
San Marcos
Escondido
Carlsbad
La Costa
Leucadia
Encinitas
Cardiff-by-the-Sea
Solana Beach
Del Mar
Rancho Santa Fe
Rancho Bernardo
Poway
Sharp Metropolitan Medical Campus
Ramona
Mira Mesa
Scripps Ranch
La Jolla
University City
Santee
Pacific Beach
Clairemont
Linda Vista
Tierrasanta
El Cajon
Mission Beach
Ocean Beach
La Mesa
Spring Valley
Point Loma
Downtown
Lemon Grove
National City
Coronado
Bonita
Chula Vista
Imperial Beach
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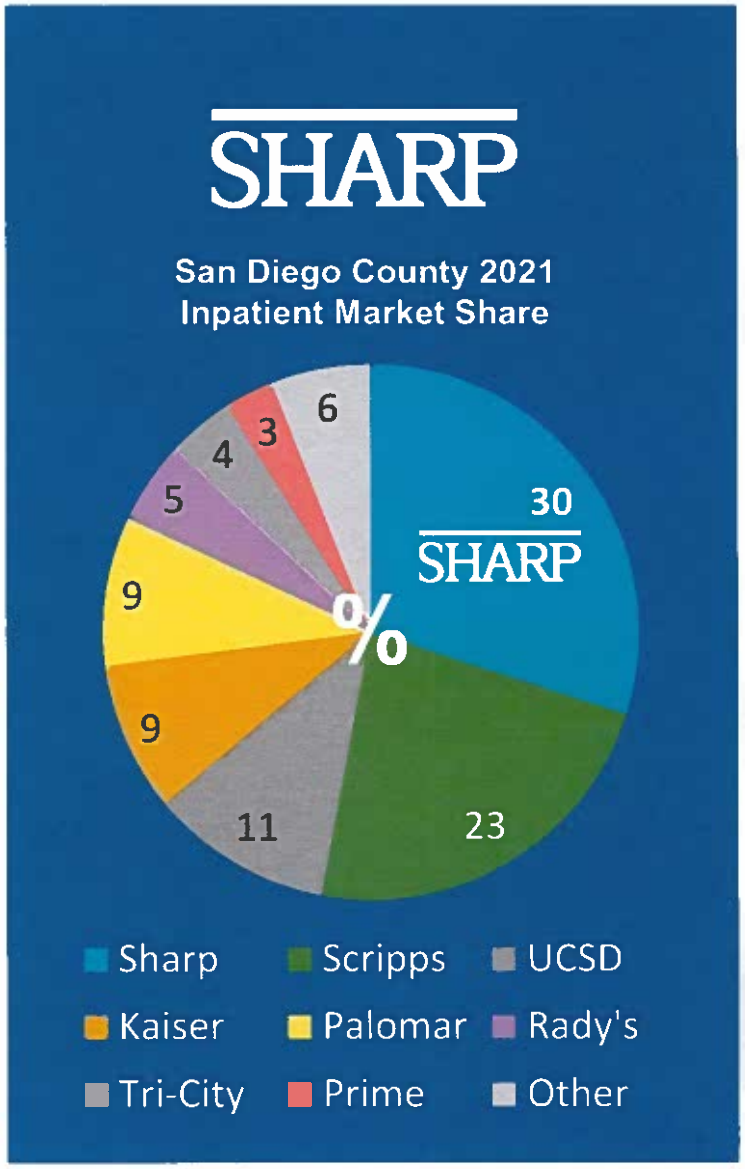

SHARP
San Diego County 2021
Inpatient Market Share
30
23
11
9
9
5
4
3
6
Sharp
Scripps
UCSD
Kaiser
Palomar
Rady's
Tri-City
Prime
Other

SHARP HEALTHCARE

- Four acute care hospitals and three specialty hospitals
- Three affiliated medical groups
- 24 outpatient clinics
- Six urgent care centers
- Two freestanding surgery centers
- A Knox-Keene licensed health plan
- Three philanthropic foundations
- An offshore captive insurance company
- Acute rehab, skilled nursing and subacute facilities
- Hospice, home infusion and specialty pharmacy
- Numerous outpatient and specialty services

SAN DIEGO'S HEALTH CARE LEADER℠

MAGNET Designation for Nursing Excellence: Sharp Grossmont Hospital (SGH), Sharp Memorial Hospital (SMH), Sharp Chula Vista Medical Center (SCVMC) and Sharp Mary Birch Hospital for Women & Newborns

First system worldwide with all acute care hospitals Planetree-designated

Press Ganey Pinnacle of Excellence and Guardian of Excellence Awards; multiple entities, 2013 – 2022

Leapfrog Hospital Safety Grades of "A" – SMH, SCVMC, SGH, Sharp Coronado Hospital and Healthcare Center, 2022

Newsweek's 2023 Best Hospitals for Maternity Care (Uncomplicated Pregnancy), SGH and SCVMC

Union Tribune Best Hospital Group (Sharp HealthCare), Hospital (SMH), Medical Group (SRS) and Health Insurance (SHP), 2022

LGBTQ+ Healthcare Equality Leader, All Sharp HealthCare Hospitals, 2022

Elite Status, Sharp Rees-Stealy Medical Group (SRS) and Sharp Community Medical Group, 2010 – 2022

Sharp Health Plan (SHP) Highest Member-Rated Plan in the State, 2015 – 2022

Hospitals & Health Networks "Most Wired," 2012 – 2021

100% Clean Power Champion Award, Sharp HealthCare, Bloom, 2022

THE SHARP EXPERIENCE EVOLUTION

Exploration | Imagination | Transformation

- Better operate as a ***system*** through best practice adoption, advancing innovation, and consolidating and modernizing IT platforms.
- Drive ***affordability*** in the market by reducing the total cost of care through standardization, site of care, and resource utilization improvements.
- Be the best place to work through the development and implementation of a comprehensive ***talent management*** plan.
- Be the best place to practice medicine through the development and implementation of a comprehensive ***physician*** strategy.
- Be the best place to receive care and drive profitable growth by expanding ***capacity*** (especially in markets with untapped potential) and establishing Sharp as the most ***consumer-friendly*** health system in San Diego.

THE SHARP EXPERIENCE

INVESTING IN THE FUTURE

Sharp is capitalizing on two key strengths – its population health focus and system integration – to become the optimal integrated delivery system

Office of Transformation	Sharp Ventures
Dedicated team driving *systemwide improvements* in patient care, operations, finance, and growth	**Alternative investments focused on *optimizing population health* to drive care delivery transformation and revenue diversification**
Tactical (11 Workstreams, Black Belts, Executive Champions)	Strategic (A1 Digital Health Fund, AXL Health, LEP Fund II)
Internal	External
Optimize Existing Processes	Create New Processes
Leverages Discipline	Leverages Agility
Build Best Sharp for Today	**Build Best Sharp for Tomorrow**

Sharp is a leading health care system nationally in the evolution of population health management and consumerism

- **Fully integrated regional health care delivery system with scale and a track record of success in strategy implementation**
- Focus on the health care experience and top decile, seven pillar performance (***The Sharp Experience***® – *Sharp's Core Competency*)
- Clinical excellence and innovation
- Information technology system integration
- Employer of choice
- Demonstrated success in medical group alignment
- Three decades of capitation experience, care coordination and focus on wellness
- **Integrated health plan (#1 member-rated plan in the state)**
- Operational success and debt capacity (strong financial position)
- Identified high-quality, cost-effective provider
- **Market leader** position in San Diego County (21 out of 22 years of market share growth)
- Community support

Sharp HealthCare's Experience with Grossmont Healthcare District

SHC – Quality & Safe Care

Commitment to high reliability evidenced by:

- All hospitals: CMS 4- & 5-star ratings
- All hospitals: Leapfrog A
- All hospitals: Planetree Gold-level designation
- Sharp Health Plan: 5-star rating 2023

Finance

Sharp-funded capital investment at (Since FY13):

$394M

Savings on interest expense:

$7.5M (due to Sharp's favorable bond rating (FY02-FY22)

Insurance savings:

20% (due to Sharp's self-insured status)

Volume

Sharp Grossmont Hospital market share growth:

	1998	2021
IP SDC:	7%	10%*
IP East Co:	30%	38%
ED visits:	45K	>100K*

* Most of any single-entity, adult acute care site in SDC

Sharp Health Plan covered lives: 150,000

SHC serves 1/3 San Diegans

Sharp HealthCare's Experience with Grossmont Healthcare District

Workforce

- **Growth of Hospital Staff:**

  1997: 1890 employees
  2022: 3925 employees

- **Growth of Medical Staff**

  2000: 642 providers
  2022: 723 providers

- **Growth of Volunteers**

  1997: 60,000 hours
  2022: 95,000 hours

Advanced services

Full spectrum of services from NICU and Hospice including:

- Comprehensive Stroke Center designation
- Neuroscience Center
- Burr Heart & Vascular Center
- SDC Hospice & Palliative Care
- SDC Specialty Pharmacy

Keeping healthcare local

Without SGH…

- Scripps closed East County hospital in 2000; Kaiser purchased the land in 2002 with no plans to build
- Closest hospital is 10-minute drive; closest specialized facilities are 17-19 minutes away

THE OPPORTUNITY AT HAND

IMPROVING THE HEALTH & WELL-BEING OF THE LOCAL POPULATION THROUGH SHARP'S INTEGRATED SOLUTION

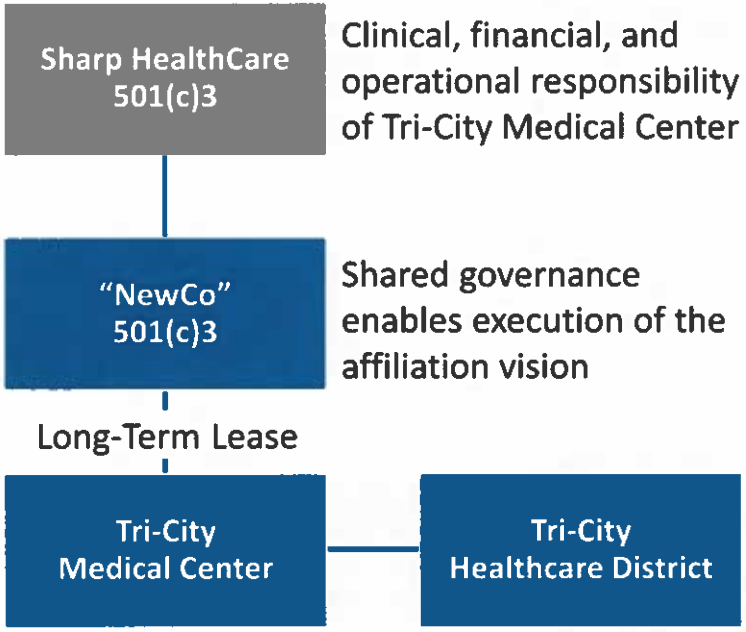
What Sharp believes:

- Tri-City Medical Center's service area has never had an offering that **represents an integrated system of health with a locally governed organization**
- Sharp HealthCare believes **investment in essential health care services allows more care to be delivered locally** and improves clinical quality
- To **accomplish our vision, the opportunity at hand will require extensive investment and focus** on the best way to fulfill North County's evolving healthcare needs

SUMMARY OF PROPOSED AFFILIATION

SELECT KEY AFFILIATION ELEMENTS **(APPROVED BY SHARP HEALTHCARE BOARD OF DIRECTORS)**

Affiliation Structure Overview



Tri-City Healthcare District will continue to own Tri-City Medical Center (TCMC)

Key Element	Proposed Term
Lease	**Long-term lease** (30 years), consistent with the Health and Safety Code and subject to voter approval
Foundation	TCMC Foundation will remain a **separate, supporting entity of TCMC** and all current and future funds will be utilized solely for the intended purposes
Governance	NewCo will be governed by a board of directors that includes **representation from TCHD, members of TCMC medical staff, community representatives elected by Sharp, and certain ex officio directors**
District Role (in addition to NewCo Governance)	Community Benefits Committee: informs Sharp support for local community benefit programs Community Initiative Funding: upon TCMC reaching financial viability, Sharp would provide funds for community investment Community Health Needs: active participation in community health needs assessments

MASTER SITE PLAN OVERVIEW

Development of a mutually agreeable Master Site Plan is a critical success factor to executing the proposed affiliation and will form the vision and plan for GO Bonds to be issued by TCHD, as and when appropriate to do so

The Master Site Plan will design TCMC's campus to achieve seismic compliance, support a new hospital tower and related facilities development, and articulate other elements such that **TCMC provides affordable, modernized care to the community.** Key components of the Master Site Plan

Service Mix to Meet the Evolving Community Needs

Number of Inpatient Beds to Support Growth and Demand

Ambulatory Investments to Support Patient Access

Based on Sharp's current knowledge of the seismic compliance information supplied by TCMC and available through HCAI, **Sharp intends to continue operating TCMC's facilities and hospital beds (i.e., approximately 175) that meet the seismic standards for 2030**

SUMMARY OF PROPOSED AFFILIATION

SELECT KEY AFFILIATION ELEMENTS (continued)

Key Element	Proposed Term
Capital and Financial Investment	**Sharp will invest significant capital** to develop the ambulatory and physician network, deploy Epic EHR, support working capital, invest in routine and strategic capital, expand Sharp Health Plan, and other similar opportunities; initial **estimates expect this to be $375 million over the first 3–5-year period**, as further detailed on the following page
New Hospital Tower	Future development of a new hospital tower and the campus post-closing will be based on the Master Site Plan and funded through GO Bonds issued by TCHD, which are subject to voter approval, and/or cash provided by operations. **Voter approval of GO Bonds is not a condition of closing the proposed affiliation.**
Core Services	The Master Site Plan will identify any "core services" Sharp would commit to operate post-closing on both a short-term and long-term basis
Providers	Sharp intends to **maintain TCMC's existing provider relationships in place**; Sharp is committed to providing Sharp Rees-Stealy Medical Group, Sharp Community Medical Group and independent provider options for provider alignment
Staff	Sharp's goal is to build and enhance TCMC's operations, supported by TCMC's achievement of key staffing and other targets in its turnaround plan. **Sharp will offer employment to all of TCMC's staff in good-standing** at closing.

SHARP HEALTHCARE CAPITAL INVESTMENT

SHARP IS PREPARED TO INVEST AN ESTIMATED $375 MILLION IN THE FIRST THREE-TO-FIVE YEARS OF THE LEASE AND AFFILIATION TRANSACTION

- Refresh of Master Site Plan
- At risk for operating performance
- Implementation of Epic EHR
- Assumption of long-term debt
- Funding of working capital
- Investment in primary and specialty care
- Aggressive expansion of Sharp Health Plan in TCMC Community
- Build-out of on-campus medical office building
- Ongoing campus repairs and maintenance

SUMMARY OF PROPOSED AFFILIATION

SELECT KEY AFFILIATION ELEMENTS (concluded)

Key Element	Proposed Term
Debt	• **Sharp will assume TCMC's future debt obligations** • Any debt of TCMC held separately from Sharp's obligated group (e.g., TCMC's HUD financing) shall be supported by Sharp's full faith and credit to ensure TCHD meets its debt obligations (to the extent not covered by tax revenues or cash flow from TCMC operations) • Sharp will work with TCHD to evaluate the overall approach to its debt such that outcomes are optimized for all parties involved
Pre-Close Support	• **To support execution of TCMC's turnaround plan, Sharp will enter into a management services agreement** with TCMC for the period between signing of definitive agreements and closing • **Sharp will also provide up to $50 million in operating funding** to cover any working capital deficits between signing of definitive agreements and closing
Other Matters	• TCHD will assure continuation of supplemental funding currently received by TCMC such as tax revenues and intergovernmental transfers • Sharp will work with TCHD to address any pre-closing requirements such as debt refinancing and other similar and customary matters • Sharp will have a right of first refusal to purchase TCMC should TCHD seek to sell, assign, or transfer all or any portion of its assets to a third party • Upon expiration of the lease unless extended by TCHD voter approval, TCMC will revert back to TCHD, subject to the terms of the lease and provisions of the Health and Safety Code

FIRST 12 MONTHS TIMELINE

EXECUTE LEASE AND AFFILIATION TRANSACTION DOCUMENTS, PLAN FOR NORTH COUNTY EXPANSION, AND SEEK VOTER AND REGULATORY APPROVALS

- Management Services Agreement
- $50 million working capital support for TCMC's operations and turnaround plan
- Integration plan
- Master Site Plan
- Physician recruitment and development
- Sharp Health Plan expansion
- Timeline for Epic implementation
- Post-closing net working capital and long-term debt
- Routine post-closing capital and facility improvements

PROVEN RESULTS – TRACK RECORD OF SUCCESS

Sharp is the best long-term partner for Tri-City Healthcare District, Tri-City Medical Center, and the communities you serve

Sustained Operating Performance	✓ **Demonstrated trend of profitability, even through the pandemic** ✓ Strong operating cash flow ✓ **Effective management of operating expenses**
Strong Financial Profile and Metrics	✓ **Diversified revenue base (health plan, clinics, capitation)** ✓ Strong debt service coverage and liquidity, coupled with modest leverage ✓ Best practice revenue cycle strategies
Stable and Effective Leadership Team	✓ Seasoned executive team and effective succession planning process ✓ Track record of successfully implementing strategies ✓ Extensive list of clinical and service innovations ✓ **Focus on systemness, innovation and consumerism**
Sound Strategic Plan and Capital Program	✓ Future capital focused on growth ✓ Established long-range strategic and financial plans
Demonstrated Market Leader	✓ 21 of 22 years of market share growth ✓ **Consistently identified as low-cost, high-quality provider** ✓ San Diego's most comprehensive health care delivery system ✓ Top decile patient and member satisfaction
Solid Physician Relations, Committed Employees, and Strong Community Support	✓ Well-established and successful affiliation with three medical groups ✓ Successful working relationship with Grossmont Healthcare District ✓ Top decile employee and physician satisfaction ✓ Successful philanthropy program ✓ All Ways Green

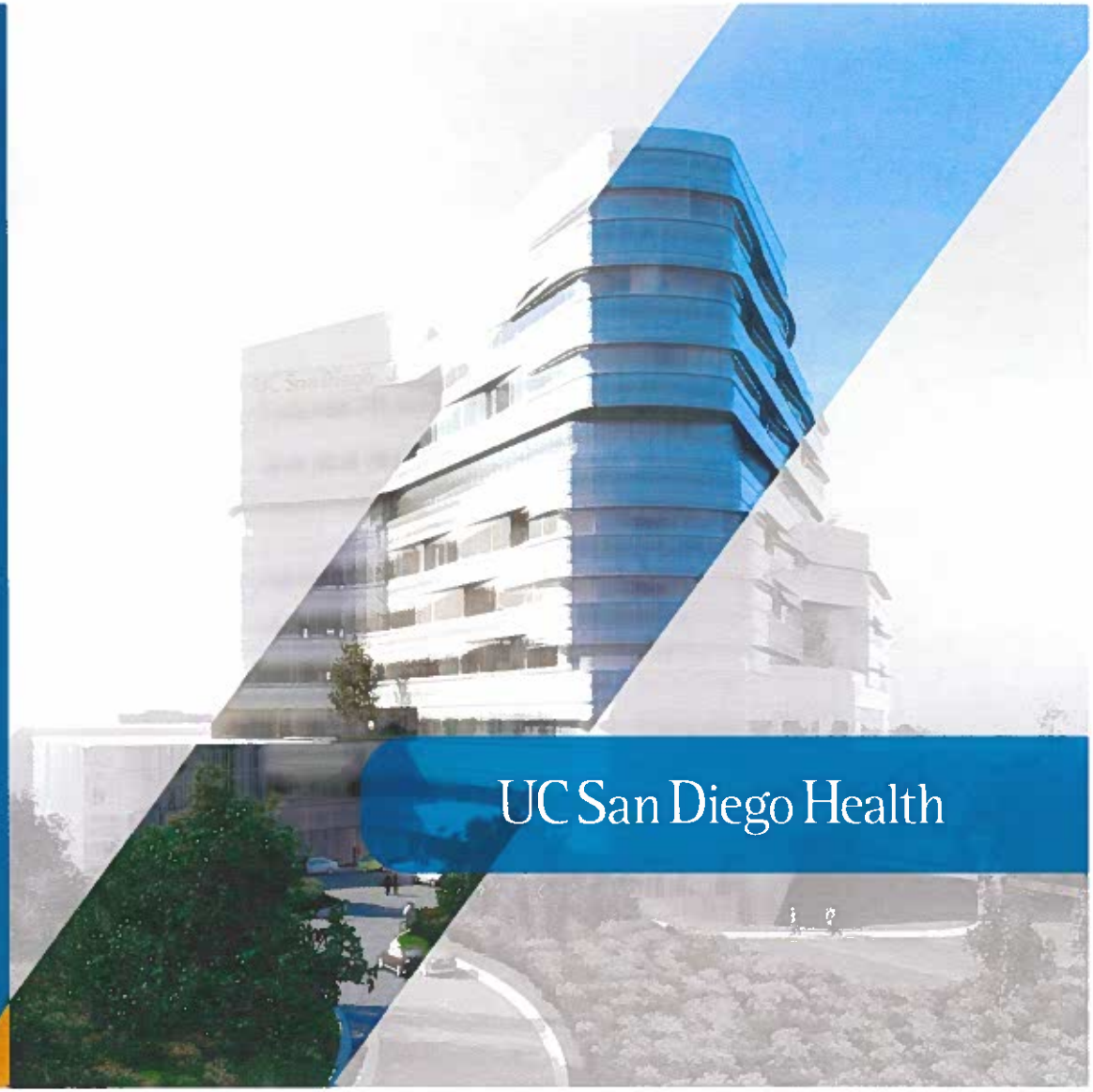
Joint Powers Agreement Proposal

Presentation to Tri-City Healthcare District Board of Directors

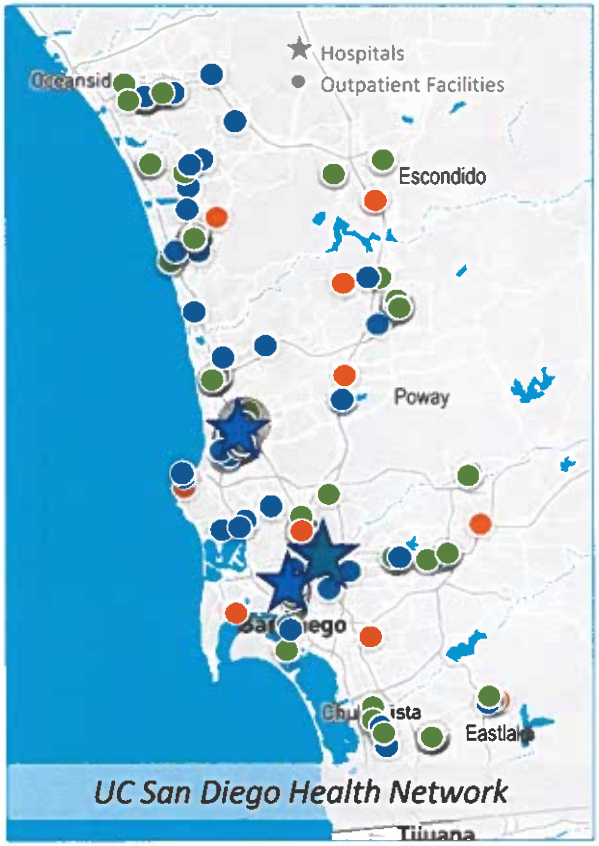
Pradeep K. Khosla
Chancellor, UC San Diego
Joan and Irwin Jacobs Chancellor's Endowed Chair

Patty Maysent
Chief Executive Officer, UC San Diego Health

October 26, 2023



UC San Diego Health Quality & Vision



#1 BEST HOSPITALS U.S.News HONOR ROLL
IN SAN DIEGO
& BEST HOSPITALS NATIONAL HONOR ROLL
Ranked in 10 Specialties

CMS ★★★★★

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

vizient.
Quality Leadership Award
vizient.
#5

HEALTHCARE EQUALITY INDEX
LGBTQ+ HEALTHCARE EQUALITY
2022
LEADER

LEAPFROG HOSPITAL SAFETY GRADE
A SPRING 2023 Hillcrest
A SPRING 2023 La Jolla

10-YEAR VISION

Become a top 10 nationally recognized health system through the development of **world-class destination programs** and **broad community outreach and service.**

UC San Diego Health By the Numbers

- $3.6 Billion+ Health System
- 13,000+ Health System Employees
- 1.12M+ Ambulatory Visits
- 635,000+ Imaging Exams
- 34,000+ Annual Hospital Admissions
- **25,000+ Cancer Care Patients Served**
- **5,000+ Births Each Year**
- 2,200+ Clinical Trials (at ACTRI)
- 2,100+ Medical Interpretations for Spanish-Speaking Patients

Community Commitment

UC San Diego Health has a longstanding mission to ensure comprehensive, equitable care for all members of the community regardless of demographics, insurance coverage, or income – with an assurance of quality healthcare to all residents.

OUR COMMITMENT TO OUR COMMUNITIES

UC San Diego Center for Community Health advances health equity through many community programs and partnerships

37% Medi-Cal patients served and the highest Medi-Cal share index of major health systems in San Diego County [1]

$600M+ annually in support of community benefits including government-sponsored care and charity

[1] Medi-Cal share index measured as the percent share of Medi-Cal patient discharges divided by the percent share of all patient discharges as of CY 2020

UC Health for Californians

HEALTH CARE

- California's third largest health system
- Performs 50% of all transplant surgeries in California
- 40% of patients uninsured or on Medi-Cal

SYSTEM STRENGTHS

- Access to financing debt
- Access to payer contracting

EDUCATION & TRAINING

- Nation's largest health sciences educational system
- 20 professional schools at 7 campuses
- UC trains 60% of state's medical students

UNIVERSITY OF CALIFORNIA HEALTH

Tri-City Medical Center

Expert Medical Care

Nationally certified programs in stroke care, heart failure, pulmonary rehabilitation, and cardiac rehabilitation

State-of-the-art technology including two fully-digital cardiac cath labs and home to the first GE 512 CT Scanner in San Diego County

Robotic and minimally invasive surgical techniques including Intraoperative Radiation Therapy and the Mazor Renaissance Surgical System for spine surgery

Community Support

Active community engagement through outreach initiatives & financial support to address the healthcare needs of all residents

Behavioral health programs and partnerships offering resources to close care gaps and expand access

Improving access to care through a broad network of dedicated community physicians

Advanced Medicine

Named to USNWR **National Honor Roll and #1 in San Diego**: nationally ranked in 10 specialties

Region's only NCI-designated **Comprehensive Cancer Center** with access to **breakthrough clinical trials**

Nationally certified programs in comprehensive stroke services, chronic kidney disease care, and multi-organ transplants

Innovative Achievements

Personalized immunotherapy cancer services from a team of physicians setting treatment standards nationwide for more than 200 types of cancer

Joan & Irwin Jacobs Center for Health Innovation accelerates the adoption of new technologies including Artificial Intelligence (AI)-powered predictive healthcare

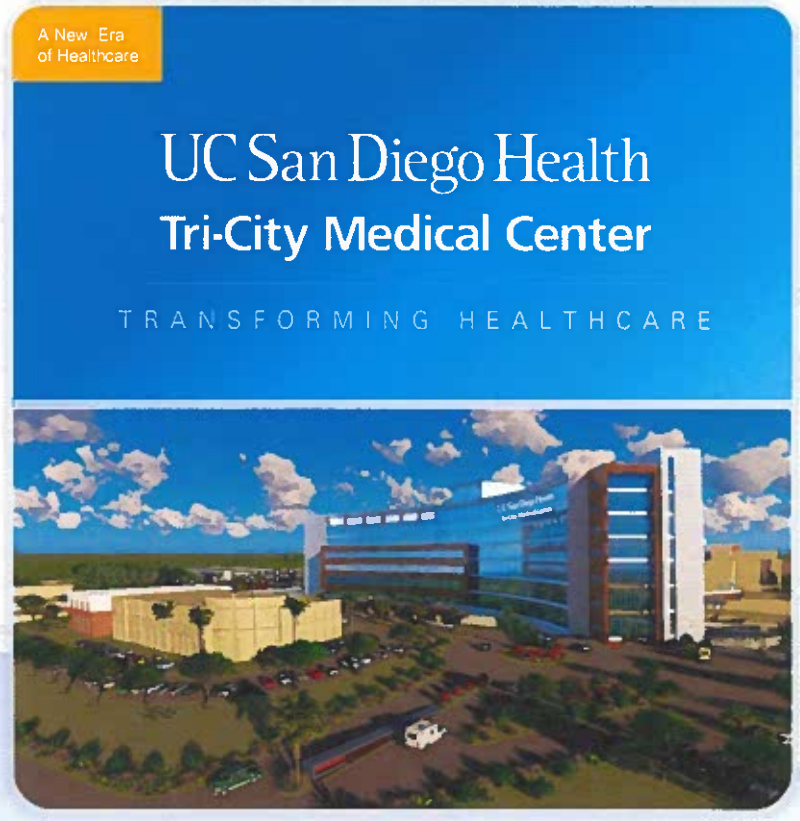
Leading national organ transplant destination; first in the nation for 3-year survival rates for lung and heart transplants and top ten for kidney and liver transplants

Pipeline development for new physicians, APPs

UC San Diego Health

The Best of Both Worlds

Together – **launching a new era of healthcare** in North County to provide world-class services, improve facilities, and advance technological capabilities



Conceptual vision of a new UC San Diego Health | Tri-City Medical Center campus

Strategic Partnership Principles

- **Provide care locally** with accessible, convenient facilities and providers
- **Deliver world class medical care** to North County with expanded clinical programs
- **Revitalize and modernize medical facilities** to create a contemporary environment of care
- **Retain and hire existing workforce** under UCSD, recognize existing labor relationships
- **Enhance patient / employee experience** through partnership, collaboration
- **Enhance behavioral health services** through advanced clinical services
- **Create a financially sustainable model** for District & residents while improving care quality
- **Develop new capabilities including** destination centers & clinical programs
- **Leverage best-in-class technology** to facilitate continuity of care for patients, clinicians
- **Embrace all communities served** regardless of demographics or insurance coverage

Joint Powers Agreement

UC San Diego Health and Tri-City Healthcare District develop a joint powers agreement (JPA) whereby UC San Diego Health assumes healthcare operations, assets, and liabilities related to healthcare delivery services to expand clinical programs available to district residents

UC San Diego Health
Long-term Alliance with Tri-City Healthcare District

- **Hospital operations** managed by UCSD with provisions to preserve certain powers under the Tri-City Healthcare District
- **Clinical collaboration** with regional providers to deliver expanded and enhanced services to the community
- **Epic EHR** implementation in Tri-City hospital, clinics, and regional medical groups
- **Health plan contracts** under UCSD arrangements including PPO and HMO plans

Long-term commitment to ensure the sustainability of high-quality services to district residents:

- Clinical service enhancements
- IT modernization
- Specialty institutes
- Payer networks
- Physician recruitment
- Community partnerships

STRUCTURE & GOVERNANCE

- **Tri-City Healthcare District transfers assets** used for the provision of healthcare operations to UC San Diego Health
- **UC San Diego Health assumes management of healthcare operations** including clinical, financial, and administrative services to expand available resources to North County residents
- **UC San Diego Health assumes liabilities** of the Tri-City Healthcare District including the outstanding portion of 2017 HUD-secured loan
- **The JPA will establish a Community Board** comprised of appointees from the District board, the Tri-City medical staff, and UC San Diego Health
- **UC San Diego Health will hire Tri-City staff**
- **UC San Diego Health will maintain the open medical staff structure** with Tri-City physicians credentialed under a separate non-academic track
- **Planning for inpatient and outpatient facilities revitalization**, size and scope to be determined by estimated volumes and available funding

UC San Diego Health Operational Initiatives

UC SAN DIEGO HEALTH PROPOSALS

Working together to positively transform healthcare in North County

Management / Operations	Facility Upgrades	Clinical Program Development	Physician Alignment	Employee Transition
Management Structure UCSD provides path to financial stabilization under a JPA with the District; UCSD manages all operational, clinical, financial aspects of services provided across existing facilities	**MOB Build-Out** Improvements to existing shelled space of 50k sf on-campus MOB	**Destination Programs** Expand regional clinical programs in collaboration with existing medical groups to add access, advanced care	**Network Expansion** Develop a consolidated, regional network of existing providers aggregated under the UCSD clinically integrated network model	**Staff Employment** Transition of existing staff to UCSD employment and extension of labor relations agreements under UCSD
Governance Structure Oversight provided by a delegated board comprised of representatives from the District and UC San Diego Health	**Hospital Tower** Redevelopment plan with potential for replacement tower upon operational stability. Minimum threshold operation: 175 seismically compliant beds	**Labor & Delivery** Expansion of Women's Health services and re-capture of deliveries through promotion and community partnerships	**Physician Recruitment** Placement of UCSD and UCSD-affiliated specialty and primary care physicians to supplement existing medical groups	**Employee Engagement** Staff well-being and engagement programs to ensure a healthy culture and dedicated workforce
	Capital Projects Facilities upgrades related to general maintenance, safety, modernization	**Cancer Services** Infusion center, cancer clinics, radiation oncology, clinical trials		

UC San Diego Health Operational Initiatives

UC SAN DIEGO HEALTH PROPOSALS

Working together to positively transform healthcare in North County

IT Infrastructure Modernization	Access & Quality Enhancement	Health Plan Contracting	Market Expansion	Health Equity
Epic EHR Implementation Inpatient and outpatient suite of Epic clinical care, scheduling, revenue cycle, patient portal, and other modules – including associated interfaces	**Quality Initiatives** Development of safety and quality initiatives with designated program directors focused on improving national public profile	**Payer Partnerships** Expand existing UCSD payer arrangements and develop new health plan products for regional employers	**New Market Growth** Capture new market share in North County through enhanced clinical services lines (cancer, cardiovascular, neurosurgery, GI, etc.) in collaboration with regional medical groups	**Access for All** Extension of UCSD's commitment to improving access for all members of the community regardless of demographics or insurance coverage
Infrastructure Improvements Analysis, recommendations, and upgrade of existing systems including cybersecurity, data-loss prevention, and network reliability	**Access Improvement** Enhance the breadth of services available to District residents	**Exclusive Contracts** Leverage expanded network to enhance opportunities for exclusive payer contracts and direct-to-employer arrangements	**Local Care Network** Promote destination programs across North County to deliver convenience and access to medical services and offer advanced care closer to home	**Community Partnerships** Program development to re-establish connections with regional FQHCs and expand the reach of existing programs to support healthy lifestyles for all residents
	Patient Experience Improve patient experience through better care, better outcomes, enhanced facilities			

Medical Campus Redevelopment

Facility Development

Creating a destination medical campus featuring:

- Advanced clinical programs
- Technological innovation
- Modern amenities
- Convenient services
- Open medical staff

Developing world class facilities accessible to all residents

Outpatient Pavilion

Development of the on-campus MOB as a multi-specialty ambulatory / outpatient health center featuring:

- Comprehensive cancer care
- Radiation oncology
- Clinical trials
- Heart center
- Women's health
- Advanced imaging
- Procedure suite
- Surgery center

New Hospital Tower

Replacement of the South Tower to allow for forecasted volume expansion and enhanced clinical programs. Anticipated services include:

- Labor & delivery
- Intensive care unit
- IMU & Med/Surg beds
- Surgical suites
- Procedure rooms
- Enhanced technology

Facility Improvements and Redevelopment

On-Campus Medical Office Building

Outpatient Center: 3-story, 57,000sf medical office building of completely shelled space with the potential to house several medical specialties in a hospital-licensed facility

Inpatient Hospital Tower

Acute Care Hospital: Expansion of inpatient beds with future replacement of the South Tower. Size and scope to be determined by anticipated volumes and available funding

Information Systems Modernization

Technological Innovation

Enabling continuity of care, seamless patient transitions, and greater clinical insights across the continuum of care

Featuring best in class technology platforms

Epic

Implementation of the full suite of UCSD-optimized Epic electronic health record modules across all facilities and medical groups, including

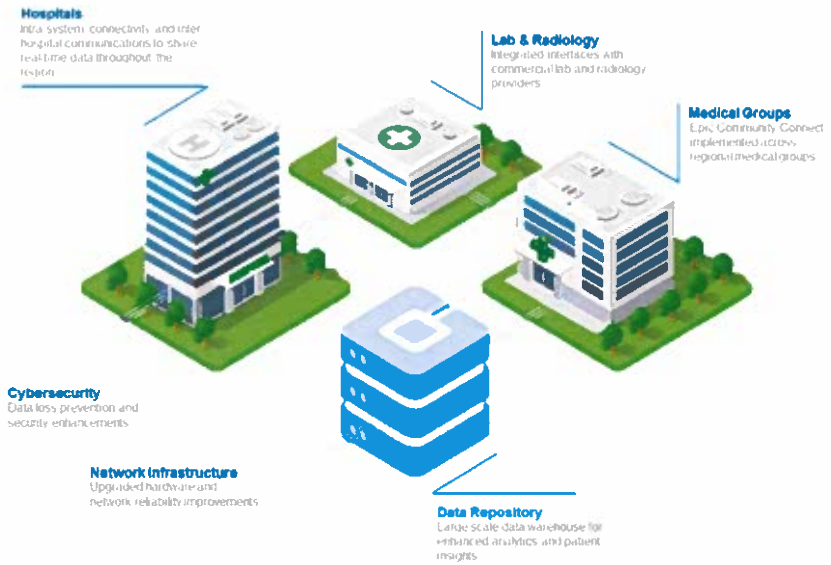
- MyChart
- Care Everywhere
- Analytics & Insights
- Healthy Planet
- Patient Scheduling
- Billing / AR
- Order Entry
- Clinical Documentation

Joan & Irwin Jacobs Center for Health Innovation

Accelerating the innovation and adoption of new technologies in healthcare, including

- Artificial Intelligence
- Remote monitoring
- Predictive analytics
- Smart workflows
- Real-time insights
- Data-driven protocols

Highly Connected Healthcare Ecosystem



Physician Alignment Strategies

Physician Alignment

Collaborating with regional physicians to supplement existing medical services and develop new clinical programs to enhance healthcare options for the residents of North County

Enhancing access to clinical services through collaboration

UC San Diego Health
PHYSICIAN NETWORK™

A clinically integrated network comprised of nearly 1,000 affiliated providers across three counties encompassing primary care and most medical specialties Benefits include

- Physician independence
- HMO / PPO contracting
- EHR offerings
- CME opportunities
- Integrated technology
- Enhanced access
- Branding/Marketing

NETWORK COMPOSITION

970 PROVIDERS	**22** SPECIALITES
67 MEDICAL GROUPS	**150+** LOCATIONS

Expansive Regional Network

UC San Diego Health Physician Network

Regional alignment through a clinically integrated network recognizing local market dynamics and offering exclusive benefits to participating members

Open Medical Staff

Maintaining the existing medical staff at Tri-City Medical Center under a community hospital model with a separate, non-academic track

1206(b) Foundation Clinics

Recognizing and retaining the existing foundation-model clinics under a similar structure within UC San Diego Health whereby physicians retain independence and administrative functions are managed by UCSD

North County

Physician Recruitment and Employment Models

Supplementing and extending existing clinical programs through physician recruitment, affiliation, and/or employment models designed to complement the existing provider network and preserve access to care in the local market


Women's Health and Labor & Delivery

Cultural Alignment

People & Culture

A deliberate commitment to enhancing the employee experience by cultivating an inclusive, purposeful environment that fosters culture, connectivity, and cohesion.

A commitment and passion to creating a better work experience

LEADING THE WAY

Unifying

Developing a shared commitment to patients across a diverse workforce

Connecting

Creating connections through shared compassion and a commitment to healing

Seeing

Ensuring the visibility and contributions of every employee across the care environment

Discovering

Understanding the perspective of others to guide the needs, preferences, and hopes of our patients

A Purposeful and Inclusive Culture

Transitioning employment to UC San Diego Health

Magnet Status

A nationally acclaimed nursing team where career-driven health care professionals gain continuous education, personal growth and professional development

Equity, Diversity, Inclusion

Cultivating a diverse workforce that welcomes employees of all backgrounds, experiences, and perspectives to achieve mutual goals in the delivery of healthcare

Labor-Friendly Culture

Recognizing and embracing the multiple labor unions representing caregivers, clerical staff, and support personnel required to deliver outstanding patient care

Culture of Belonging

Creating an environment where employees feel connected to each other and to a unifying purpose in alignment with the culture and values of UC San Diego Health

Partnership Summary

UC San Diego Health **Tri-City Medical Center**

PUBLIC-PUBLIC PARTNERSHIP

- **Joint Powers Agreement (JPA)**
  - Long-term commitment
- **Focus on Health Care Needs**
  - Service revival, expansion
  - Health Equity
  - Medi-Cal
  - Community Health Benefits
- **Clinical collaboration**
- **Network Relationships**
  - HMO, PPO
  - FQHCs

STRUCTURE & GOVERNANCE

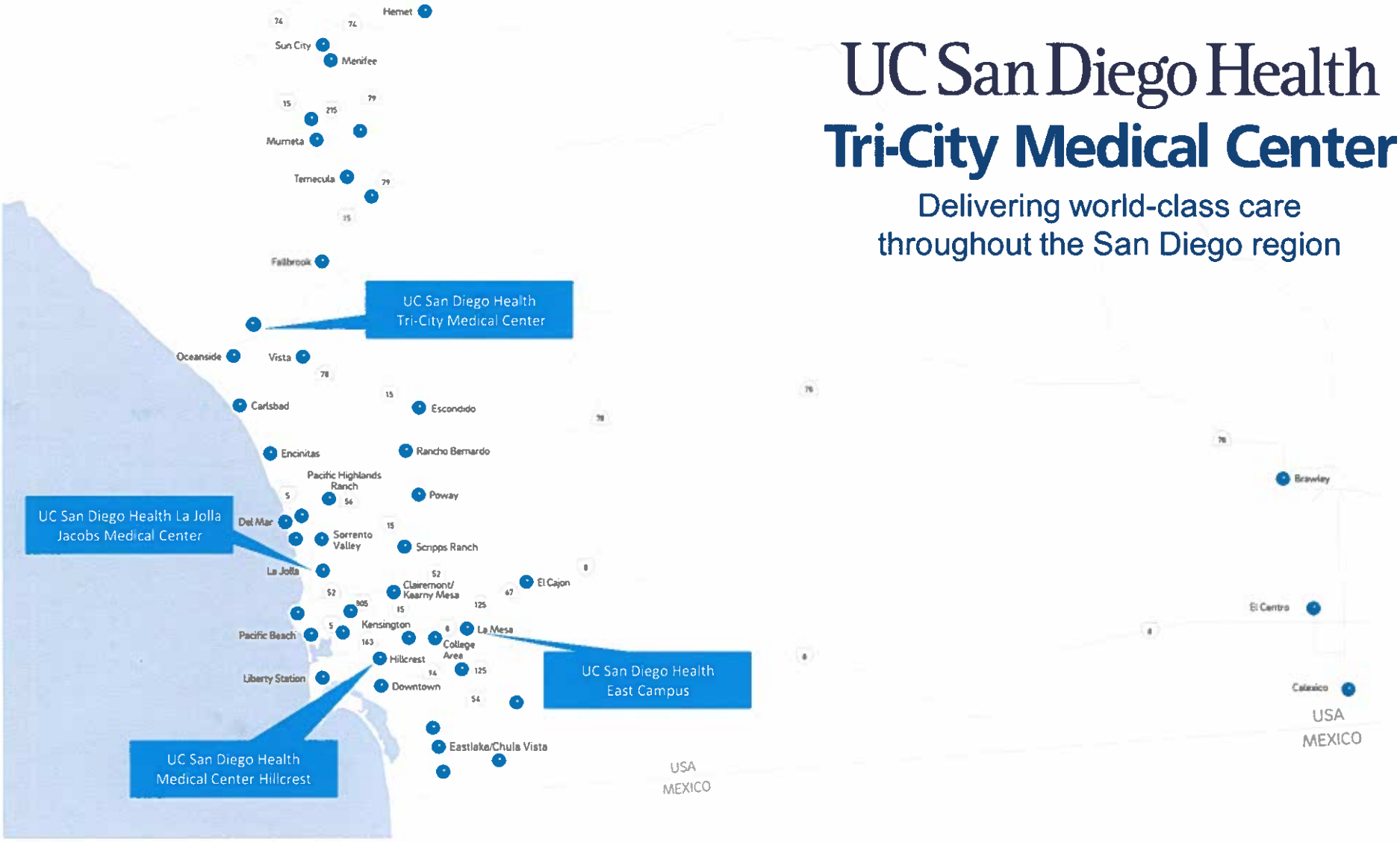
- **Tri-City Healthcare District transfers assets**
- **UC San Diego Health assumes liabilities**
- **UC San Diego Health to manage all healthcare operations**
- **Establishment of a Community Board** with representatives from Health District, Tri-City Med Staff, and UC San Diego Health
- **UC San Diego Health maintains open medical staff structure**

IMPROVEMENTS & SERVICES

- **Inpatient and outpatient facilities redevelopment**
- **Technology improvements**
  - Electronic Health Record (Epic)
- **Quality enhancements**
- **People and culture**
  - Ensuring everyone feels valued, cared for, and belongs
- **Access expansion**
- **Excellent world-class care** for all North County residents

UC San Diego Health
Tri-City Medical Center

Delivering world-class care throughout the San Diego region



Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending October 31, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm 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)	37,353.94	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)	20,594.69	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	18,075.40	10/01/22	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	$2.21	(a)	7,158.60	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)	15,620.89	05/14/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,811.92	09/01/21	08/31/33	**PCP Clinic Carlsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
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
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	32,470.00	10/01/22	09/30/25	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	14,880.52	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	$2.21	(a)	7,209.02	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**243,090.91**				

(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 October 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7095	CONTROLLED SUBSTANCE CLASS	72423 EDU	225.00	84334	JOHNSON RYAN
8390	2 EA Pyxis ES System Manager C	6000037156-2	6,600.00	79204	CAREFUSION SOLUTIONS LLC - PYX
8740	ACLS	92823 EDU	200.00	80229	LILLY REED , ANNETTE
8740	AHA ACLS	92823 EDU	200.00	82540	JULIE ANCHESTIGUI
8740	CCRN	102023 EDU	200.00	83345	LEROY, TONYA
8740	CRCST EXAM	92223 EDU	140.00	84316	SPINELLI VIRGINIA
8740	DIABETIC	92223 EDU	100.00	84317	ZULU CATHERINE
8740	BSN NURSING	91523 EXP	2,000.00	84318	ALLEN CHRISTINA

**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.