TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 28, 2024 – 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	February 2024 Financial Statement Results	10 min.	CFO
6	New Business – a) Approval of the renewal of an agreement for the Medical Directorship for Opioid Stewardship Program with Ole Snyder, M.D., for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, for an annual and total term cost not to exceed $18,000. b) Approval of an agreement with Infor (US), Inc. for software support for a term of 12 months, beginning June 1, 2024 and ending May 31, 2025 for a total cost for the term of $459,384.	5 min. 5 min.	COO CIO
7	Old Business – a) Affiliation Update – Information Only	5 min.	CEO
8	Chief of Staff - a) Consideration of March 2024 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 25, 2024.	5 min. .	COS

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

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

	Agenda Item	Time Allotted	Requestor
9	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee** **Director Younger, Committee Chair** *(Lack of Quorum)* (2) **Administrative Policies & Procedures** **A. Patient Care Services** 1) Code Caleb Response Plan Policy 2) Constavac Reinfusion of Blood Procedure 3) Electrocautery Machine Setup, Use and Safety Procedure 4) Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy 5) Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure 6) Gowning & Gloving Procedure 7) High Level Disinfection Procedure 8) HIV Testing: In an Occupational Exposure 9) Labeling Medication on and off the Sterile Field Procedure 10) Missing Patient 11) Obstetrical Patients Triage Policy 12) Pneumatic Tourniquet Use and Safety Procedure 13) Single Use Device, Reprocessing Procedure 14) Skin Antisepsis, Surgical/Procedural Policy 15) Special Order Durable Medical Equipment (DME) and Specialty Beds Policy 16) Surgical Attire Policy 17) Utilization of Staff, Staffing Patterns Policy 18) Wound VAC, Negative Pressure Therapy Policy **B. Administrative 300 Patient Care** 1) Conditions of Admission Form Delivery 2) Event Reporting 396 **C. Administrative 500 Compliance** 1) Business Associate Agreement Policy 511 2) Controls and Monitoring of Payments to Physicians or Other Referral Sources 576 3) Faxing of Protected Health Information (Medical Records) 522 4) Hospital Issued Notice of Noncoverage of Medicare-Covered Services (HINN) 398 5) Important Message From Medicare and Notification of Hospital Discharge Appeal Rights 392 6) Notice of Privacy Practices Policy 518 **D. Infection Control** 1) Infection Prevention Program Plan 2) Infection Prevention Risk Assessment 3) Required Reporting Policy **E. Medical Staff** 1) CME Speaker & Honoraria Reimbursement 8710 – 604 2) Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710 – 600	10 min.	

	Agenda Item	Time Allotted	Requestor
	3) Joint Providership Co-Providership 8710- 602 4) Regularly Scheduled Series (RSS) 8710-606 **F. Pharmacy** 1) Medication Error Reduction Plan (MERP) **G. Pulmonary** 1) Pulmonary – Scope of Services **H. Rehabilitation** 1) NICU Scope & Qualifications 505 **I. Surgical Services** 1) Anesthesia Equipment Policy 2) Block Time Policy 3) Bumping Surgery Procedures Policy 4) CPR in Surgical Services Policy 5) Food & Drink, Surgery Policy 6) Hysteroscopy Policy 7) Operating Room (OR) Committee Policy 8) Patient Transport to the Perioperatiave Environment Policy 9) Perioperative Documentation 10) Perioperative Standards of Practice Policy 11) Positioning the Surgical Patient Policy 12) Protective Barriers, Materials for Gowns and Drapes Policy 13) Scope of Service for Surgical Services Policy 14) Standard Precautions in Surgery Policy 15) Surgical Patients with Implanted Electronic Devices 16) Surgical Supply Stocking, Rotation and Outdate (3) Minutes a) Special Meeting – February 28, 2024 b) Regular Meeting – February 24, 2024 (4) Reports – (Discussion by exception only) a) Building Lease Report – (February, 2024) b) Reimbursement Disclosure Report – (February, 2024)		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications	18 min.	Standard
14	Total Time Budgeted for Open Session	1 hour	
15	Adjournment		

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MARCH 28, 2024
MEDICAL DIRECTOR - OPIOID STEWARDSHIP PROGRAM

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

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

Area of Service: Medical Director- Opioid Stewardship Program

Term of Agreement: 12 months, Beginning, May 1, 2024 – Ending, April 30, 2025

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

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

Description of Services:

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

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

Person responsible for oversight of agreement: Ellen Langenfeld, Director of Pharmacy Services / Gene Ma, M.D., Chief Executive Officer

Motion:
I move that the TCHD Board of Directors authorize the renewal of the Medical Directorship for Opioid Stewardship Program with services provided by Ole Snyder, M.D. for a term of 12 months, beginning May 1, 2024 and ending, April 30, 2025, for an annual and total term cost not to exceed $18,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: MARCH 28, 2024
SOFTWARE SUPPORT PROPOSAL

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

Vendor's Name: Infor (US), Inc.

Area of Service: Finance & Information Technology

Term of Agreement: 12 months, Beginning June 1, 2024 - Ending May 31, 2025

Annual / Term Cost
$459,384

Description of Services/Supplies:

- Software support for Lawson System Foundation, as well as the following sub-systems:
  - Financials Asset Management
  - Financials Account Payable
  - Financials General Ledger
  - Payroll
- Additionally, this agreement covers TCMC's interface engine (Cloverleaf).
- This represents an increase of $26,337 to the previous agreement.

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

Person responsible for oversight of agreement: Mark Albright, Chief Information Officer

Motion:
I move that the TCHD Board of Directors authorize the agreement with Infor (US), Inc. for software support for a term of 12 months beginning June 1, 2024 and ending May 31, 2025 for a total cost for the term of $459,384.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 13, 2024

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 3/29/2024 – 2/28/2026)

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 3/29/2024 through 2/28/2026:

- **AFRIDI, Faraz MD/Critical Care (Vituity)**
- **BLAIZE, Marie MD/Internal Medicine - Telemedicine (Sound)**
- **LI, Robin MD/Anesthesiology (ECHO)**
- **NATARAJAN, Sabareesh MD/Neurosurgery (Brain, Spine & Vascular Neuroscience Institute)**
- **VORA, Shivani MD/Critical Care (Vituity)**
- **WHITE, Daniel MD/Neurosurgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
March 13, 2024

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 04/01/2024 – 3/31/2026)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 04/01/2024 through 03/31/2026, 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:

- **AVILA, Afonso, DO/Emergency Medicine/Provisional**
- **BALL, Lindsey, MD/Emergency Medicine/Active**
- **BASERI, David, MD/Oncology/Provisional**
- **BERRY, Julie MD/Otolaryngology/Active**
- **DALLA BETTA, Michael B., DO/Emergency Medicine/Active**
- **GARRISON, David MD/Critical Care/Provisional**
- **GILL, Puneet, MD/Telemedicine/Provisional**
- **LE, Charles, MD/Nephrology/Provisional**
- **PARK, Gregory, MD/Plastic Surgery/Refer and Follow**
- **SANTIAGO-DIEPPA, David, MD/Neurological Surgery/Provisional**
- **SHIM, Michael, MD/Gastroenterology/Active**
- **RUTTENBERG, Todd DO/Emergency Medicine/Provisional**
- **SAXON, Richard R., MD/Interventional Radiology/Active**
- **SHUMATE, Wendy A, MD/Internal Medicine/Active**
- **SNYDER, Ole W., MD/Family Medicine/Refer and Follow**
- **TERRAMANI, Thomas T, MD/Vascular Surgery/Active Affiliate**
- **YOO, Frank, MD/Neurological Surgery/Active**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
March 13, 2024

Attachment B

UPDATE TO NOVEMBER REAPPOINTMENT:

- **BARVALIA, Mihir, MD/Cardiology**
  The provider is requesting TAVR, Watchman and Percutaneous device for PFO and ASD privileges and has met criteria for the privileges **WITH** proctoring.

RESIGNATIONS: (Effective date 3/31/2024 unless otherwise noted)

Automatic:
- **BUTLER, Ian MD/Critical Care/Provisional**

- **MARION, Phillips, MD/Oncology/Provisional**

Voluntary:
- **SAMEE, Ali, MD/Telepsychiatry**

MBOC:

- **CARR, Kenneth W., MD/Cardiology/Active**
  The provider is on a 35-month probation imposed by the CA Medical Board effective February 23, 2024. The Department Chairman has reviewed and the provider's license will be monitored for any updates.

NPDB: None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 13, 2024

PROCTORING RECOMMENDATIONS

- **BUTLER, Ian, MD**
  Release from Proctoring:
  Critical Care Medicine
  Admit patients, Consultation, including via telemedicine(F) and sleep tests/polysomnography, perform history & physical examination, including via telemedicine (F), General Critical Care and Administration of Moderate sedation.

- **FERNANDEZ, Genaro, MD**
  Release from Proctoring:
  Interventional Cardiology
  Admission of Patient in Inpatient Services, Performance of History and Physical Examination, including via telemedicine, Performance of a Cardiac Consultation, including via telemedicine, Supervision of an approved category of Allied Health Practitioner, Basic invasive procedures including Swan-Ganz Catheter insertion & monitoring and Cardiac Catheterization procedures.

- **FOOLADIAN, Siyavash, MD**
  Release from Proctoring:
  Anesthesiology
  Consultation including via telemedicine (F), Evaluate and treat patients with anesthesia related problems, perform history and physical examination, including via telemedicine (F), General Anesthesia, and Invasive Monitoring includes: Arterial line, Central line, Midline and Pulmonary Artery catheters, Cardiac Anesthesia Transesophageal Echocardiography (TEE).

- **LAREAUX, Daniel, MD**
  Release from Proctoring:
  Emergency
  Deep Sedation

- **LI, Robin, MD**
  Release from Proctoring:
  Anesthesiology
  Consultation including via telemedicine (F), Evaluate and treat patients with anesthesia related problems, perform history and physical examination, including via telemedicine (F), General Anesthesia, and Invasive Monitoring includes: Arterial line, Central line, Midline and Pulmonary Artery catheters, Cardiac Anesthesia Transesophageal Echocardiography (TEE).

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 13, 2024

- **JOSHI, Raj, MD** — **Critical Care Medicine**
  Release from Proctoring: Admit patients, Consultation, including via telemedicine(F) and sleep tests/polysomnography, perform history & physical examination, including via telemedicine (F), General Critical Care and Administration of Moderate sedation.

- **PORTER, Douglas, MD** — **Teleneurology**
  Release from Proctoring: Intraoperative Neurophysiological Monitoring and Interpretation.

- **SANTA MARIA, Amanda, MD** — **Emergency**
  Release from Proctoring: General Patient Care

- **UDANI, Vikram, MD** — **Neurosurgery**
  Release from Proctoring: Admit patients, Consultation, including via telemedicine (F), Consultation, including via telemedicine (F), History and physical examination, including via telemedicine (F), Cranial/Skull Base Category, Spine Category and Nervous System Category.

UPDATE TO JANURARY PROCTORING:

- **SHEREV, Dimitri, MD/Cardiology**
  The provider with TAVR & Watchman privileges continues WITH proctoring.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
March 18th, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Code Caleb Response Plan Policy	RETIRE	Forward to BOD for Approval
2. Constavac, Reinfusion of Blood Procedure	3 year review, practice change	Forward to BOD for Approval
3. Electrocautery Machine Setup, Use and Safety Procedure	3 year review	Forward to BOD for Approval
4. Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy	Practice change	Forward to BOD for Approval
5. Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure	3 year review, practice change	Forward to BOD for Approval
6. Gowning & Gloving Procedure	3 year review, practice change	Forward to BOD for Approval
7. High Level Disinfection Procedure	3 year review	Forward to BOD for Approval
8. HIV Testing: In an Occupational Exposure	3 year review, practice change	Forward to BOD for Approval
9. Labeling Medication on and off the Sterile Field Procedure	3 year review	Forward to BOD for Approval
10. Missing Patient	3 year review, practice change	Forward to BOD for Approval
11. Obstetrical Patients Triage Policy	RETIRE	Forward to BOD for Approval
12. Pneumatic Tourniquet Use and Safety Procedure	3 year review	Forward to BOD for Approval
13. Single Use Device, Reprocessing Procedure	3 year review, practice change	Forward to BOD for Approval
14. Skin Antisepsis, Surgical/Procedural Policy	3 year review, practice change	Forward to BOD for Approval
15. Special Order Durable Medical Equipment (DME) and Specialty Beds Policy	RETIRE	Forward to BOD for Approval
16. Surgical Attire Policy	3 year review, practice change	Forward to BOD for Approval
17. Utilization of Staff, Staffing Patterns Policy	3 year review, practice change	Forward to BOD for Approval
18. Wound VAC, Negative Pressure Therapy Policy	RETIRE	Forward to BOD for Approval
Administrative 300 Patient Care		
1. Conditions of Admission Form Delivery	NEW	Forward to BOD for Approval
2. Event Reporting 396	3 year review, practice change	Forward to BOD for Approval
Administrative 500 Compliance		

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
March 18th, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
1. Business Associate Agreement Policy 511	3 year review, practice change	Forward to BOD for Approval
2. Controls and Monitoring of Payments to Physicians or Other Referral Sources 576	3 year review, practice change	Forward to BOD for Approval
3. Faxing of Protected Health Information (Medical Records) 522	3 year review, practice change	Forward to BOD for Approval
4. Hospital Issued Notice of Noncoverage of Medicare-Covered Services (HINN) 398	3 year review	Forward to BOD for Approval
5. Important Message From Medicare and Notification of Hospital Discharge Appeal Rights 392	3 year review	Forward to BOD for Approval
6. Notice of Privacy Practices Policy 518	3 year review, practice change	Forward to BOD for Approval
Infection Control		
1. Infection Prevention Program Plan	1 year review, practice change	Forward to BOD for Approval
2. Infection Prevention Risk Assessment	3 year review, practice change	Forward to BOD for Approval
3. Required Reporting Policy	3 year review, practice change	Forward to BOD for Approval
Medical Staff		
1. CME Speaker & Honoraria Reimbursement 8710 - 604	1 year review	Forward to BOD for Approval
2. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710 - 600	1 year review	Forward to BOD for Approval
3. Joint Providership Co-Providership 8710 - 602	1 year review	Forward to BOD for Approval
4. Regularly Scheduled Series (RSS) 8710 - 606	1 year review	Forward to BOD for Approval
Pharmacy		
1. Medication Error Reduction Plan (MERP)	1 year review, practice change	Forward to BOD for Approval
Pulmonary		
1. Pulmonary - Scope of Services	3 year review	Forward to BOD for Approval
Rehabilitation		
1. NICU Scope & Qualifications 505	RETIRE	Forward to BOD for Approval
Surgical Services		
1. Anesthesia Equipment Policy	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
March 18th, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
2. Block Time Policy	3 year review	Forward to BOD for Approval
3. Bumping Surgery Procedures Policy	3 year review	Forward to BOD for Approval
4. CPR in Surgical Services Policy	3 year review	Forward to BOD for Approval
5. Food and Drink, Surgery Policy	3 year review	Forward to BOD for Approval
6. Hysteroscopy Policy	3 year review	Forward to BOD for Approval
7. Operating Room (OR) Committee Policy	3 year review	Forward to BOD for Approval
8. Patient Transport to the Perioperative Environment Policy	3 year review	Forward to BOD for Approval
9. Perioperative Documentation	3 year review	Forward to BOD for Approval
10. Perioperative Standards of Practice Policy	3 year review	Forward to BOD for Approval
11. Positioning the Surgical Patient Policy	3 year review	Forward to BOD for Approval
12. Protective Barriers; Materials for Gowns and Drapes Policy	3 year review	Forward to BOD for Approval
13. Scope of Service for Surgical Services Policy	3 year review	Forward to BOD for Approval
14. Standard Precautions in Surgery Policy	3 year review	Forward to BOD for Approval
15. Surgical Patients with Implanted Electronic Devices	3 year review	Forward to BOD for Approval
16. Surgical Supply Stocking, Rotation and Outdate	3 year review	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

RETIRE – no longer required with suspension of Women and Newborn Services

ISSUE DATE: 11/11 **SUBJECT:** Code Caleb Response Plan

REVISION DATE~~(S)~~: 02/12, 01/18, 03/16, 04/2020

Patient Care Services Content Expert~~Department~~ Approval:	~~01/18~~02/23
Clinical Policies & Procedures Committee Approval:	~~02/18~~12/23
Nursinge Leadership~~Executive Council~~ Approval:	~~03/18, 08/22~~01/24
~~Division of Neonatology Perinatal Collaborative Practice Approval:~~	~~05/18, 09/22~~
Department of Emergency Medicine Approval:	06/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~07/18~~02/24
Administration Approval:	~~08/18~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/18

~~A. PURPOSE:~~

~~To provide a systematic method for responding to a cardiopulmonary event and/or other emergent clinical conditions for infants up to 30 days of age or 44 weeks corrected gestational age, within the hospital **(except for in the Women's & Newborn Services Department [WNS])** and outside of the facility on hospital property.~~

~~1. efer to~~

~~B. DEFINITION(S):~~

~~1. Infant: newly delivered, which includes prematurely, and up to 30 days of age or 44 weeks corrected gestational age.~~

~~2. Code Caleb Response Areas:~~

~~a. Patient Care Areas- areas in the main building where neonatal crash carts are readily available (for example Emergency Department [(ED)], Women and Newborns Services, Neonatal Intensive Care Unit [NICU]).~~

~~b. Non-Patient Care Areas- areas on the main campus where neonatal crash carts are not readily available (for example the lobby, registration area, and parking area).~~

~~C. POLICY:~~

~~1. A Code Caleb shall be called for any infant in need of stabilization or resuscitation **outside of the WNS Department**.~~

~~2. Any person may initiate a Code Caleb by dialing 66 on the telephone. The operator shall announce Code Caleb and the location over the Public Announcement (P.A.) system three times, twice.~~

~~3. The Neonatal Resuscitation Program (NRP) guidelines shall be used to direct the resuscitation efforts **when the Neonatologist is the lead assisting/running the code.** for those infants on the Labor and Delivery (L&D), Mother Baby Unit and NICU.~~

~~4. The Pediatric Advanced Life Support (PALS) and/or NRP guidelines may be used to direct the resuscitation efforts for those infants requiring assistance in the ED and Non-Patient Care Areas based on the responder's training **unless the Neonatologist responds and takes over being the lead and running the code**.~~

~~5. It is expected that the first responders begin infant cardiopulmonary resuscitation (CPR) until the Code Caleb Response Team arrives.~~

~~6. The following personnel make up the Code Caleb Response Team:~~

a. NICU Nurse:
   i. Support resuscitation interventions and initiates NRP per **NRP Guidelines**Patient Care Services Standardized Procedure: Code Caleb until the Neonatologist arrives.
   ii. Bring the Infant Resuscitation Bag when responding to a Non-Patient Care Areas.
   iii. Start intravenous (IV) line, assists with central line placement as indicated.
   iv. Ensure temperature loss is minimized especially if the infant is premature.
   v. Prepare medications for administration and may delegate the task.
b. Respiratory Care Practitioner (RCP):
   i. Provide airway management.
   ii. Bring neonatal/infant airway bag if responding to Non-Patient Care Areas.
   iii. Assist with intubation.
   iv. Obtain arterial blood gases (ABG's) as indicated.
c. Neonatologist:
   i. Responds, when available, and is responsible for leading the resuscitative efforts.
   ii. Responsible for intubation and central line placement as indicated.
   iii. Determine where the infant will be transported for stabilization.

7. Other support roles and responsibilities during the Code Caleb include:
   a. Security Personnel:
      i. Maintain scene safety and keeps area clear of congestion.
   b. Assistant Nurse Manager (ANM)/Relief Charge Nurse **(RN) or designee**:
      i. Assign recorder role, if not already done.
      ii. Ensure paperwork and documentation on the Neonatal Resuscitation Record **or the Pediatric Resuscitation Record** and **any computer documentation is entered** the Emergency Event form in the patient's electronic health record (EHR), are completed.
      iii. Ensure the medication tray inside the neonatal crash cart **or Braslow Broselow crash cart** is relocked with a secure tie (located in the crash cart) for containment post code.
      iv. Ensure the opened crash cart is locked with the plastic key lock externally, is placed in a secured area and the Sterile Processing Department (SPD) is notified to pick up the used cart post code.
   c. Ancillary Support (Social Worker, Chaplain):
      i. Provide support to the family by providing comfort, presence and updates as available.
   d. SPD:
      i. Bring another Neonatal Crash Cart **or Braslow Broselow crash cart** and one (1) infusion pump with one (1) channel and one (1) syringe pump attached to the scene.

8. The response to the Code shall occur according to the following response plans.

D. RESPONSE PLAN IN L&D AND MOTHER BABY UNIT:

1. First responder at emergent event:
   a. Call for assistance or delegate someone to dial 66 for Code Caleb.
   b. Move the infant to the radiant warmer for resuscitation.
      i. On the Mother Baby Unit/ 2 South overflow, infant CPR shall begin as the infant is transported in an open crib to the radiant warmer in the transition nursery or infant treatment area.
   c. Begin ventilating the infant using positive pressure ventilation (PPV) per NRP guidelines until Code team arrives.
2. Unit Secretary/Available Staff member:
   a. Initiate a Code Caleb:

i. Dial 66 to have Code Caleb announced over the P.A. system if needed.

3. Second Responder:
   a. Assist with resuscitation per NRP guidelines until Code team arrives.
   b. Attach pulse oximetry lead.
   c. Assist with chest compressions.
4. Obstetrical Technician, Acute Care Technician/Perioperative Aide:
   a. Bring the Neonatal crash cart to the scene.
   b. Bring the Neonatal Transporter to the scene.
   c. Act as a runner for supplies, labs, etc.

E. RESPONSE PLAN IN THE NICU:

1. First Responder:
   a. Call for assistance.
   b. Begin CPR and moved infant to radiant warmer for resuscitation.
   c. Begin ventilating infant per NRP guidelines.
2. Unit Secretary/Available Staff member:
   a. Call/page the Neonatologists.
   b. Call/page the RCP.
3. Second/Third Responders:
   a. Bring Neonatal crash cart to the bedside.
   b. Assist with resuscitation per NRP guidelines.
4. Registered Nurse (RN):
   a. Assist with line placement and medication preparation as needed,.

F. RESPONSE PLAN IN THE ED:

1. First Responder:
   a. Call for assistance.
   b. Begin CPR per PALS guidelines until **the Neonatal** Code Team **if available** arrives.
2. Unit Secretary/Available Staff member:
   a. Dial 66 and requests Code Caleb be announced.
3. Second Responder:
   a. Assist with resuscitation per PALS guidelines until **the Neonatal** Code Team arrives.
4. Emergency Medical Technician (EMT):
   a. Bring the infant radiant warmer to the scene, plugs it in and turns the warming power to 100%.**Assists staff to get the baby to the warmer.**
   b. Bring the Neonatal crash cart to the scene **if code not in the ED**.
5. ED Nurse:
   a. Responsible for the initial resuscitation efforts.
   b. Collaborate with the NICU nurse and Code Caleb **Neonatal** response team upon arrival.
   c. May attempt IV access, as indicated.
   Ensure infant temperature loss is minimized especially if premature.
   d. **Getting the baby to the infant warmer that is up to 100% heat is recommended as soon as possible when the area is available.**
6. ED Provider:
   a. Direct initial resuscitation efforts.
   b. Work collaboratively with Neonatologist upon arrival.
   c. May intubate, and place an Interosseous (IO) device.

G. RESPONSE PLAN IN NON-PATIENT CARE AREAS:

1. First Responder:
   a. Call for assistance
   b. Begin CPR until the **Neonatal** Code Caleb Response Team arrives.
2. The NICU Nurse, RCP and Neonatologist:
   a. Ensure PALS or NRP guidelines have been implemented.

b. Arrange for transport to the ED or NICU as soon as possible.

H. RESPONSE PLAN AT AFFILIATED CENTERS:

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center
   k. Tri-City Wellness Center
2. Staff members are to initiate CPR and call 911 to facilitate management and transport of the infant to the ED.
3. The staff in home care, partial hospitalization, and outpatient rehabilitation services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

I. RELATED DOCUMENT(S):

1. Patient Care Services Standardized Procedure: Code Caleb

J. REFERENCE(S):

1. Neonatal Resuscitation Program (NRP), 7Th Edition (2016). American Academy of Pediatrics and American Heart Association.
2. Pediatric Advanced Life Support (PALS). 2016. American Heart Association and American Academy of Pediatrics

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CONSTAVAC®, REINFUSION OF BLOOD**
Purpose:	To provide guidelines for the RN regarding reinfusion of autologous blood via the constavac reinfusion system.
Supportive Data:	The reinfusion of collected autologous whole blood carries specific contraindications and requires specific practices
Equipment:	1. PPE 2. Constavac reinfusion system

A. **POLICY:**

1. The operating surgeon shall identify patients who are candidates for the Constavac reinfusion blood collection system in the operating room.
2. A physician's/Allied Health Professional's (AHP) order is required for blood reinfusion.
3. No reinfusion shall be initiated more than six (6) hours after the initiation of drainage.
4. The reinfusion shall be administered through blood tubing, using a forty (40) micro aggregate filter.
5. Blood tubing shall be flushed using only 0.9% NaCl solution. No other solution of medication shall be added to or administered concurrently through the same intravenous (IV) tubing.
6. Should the Constavac become contaminated or have a leak, reinfusion shall not be initiated.

B. **PACU AND INPATIENT UNITS:**

1. Upon arrival to the Post Anesthesia Care Unit (PACU) or the patient's room, the registered nurse (RN) shall assess the drain for suction and drainage.
2. The Constavac drain shall remain upright at all times.
3. The RN shall verify that the red vacuum indicator is inverted.
   a. If the red vacuum indicator is not inverted, initiate drainage by setting the vacuum dial at number II unless otherwise indicated by the physician/AHP.
4. The RN shall note the type and amount of drainage in **electronic health record (EHR)**~~Cerner~~ with each vital sign.
5. When the drainage amount has reached 300 - 400 mL, the RN shall begin the first reinfusion of autologous blood.

C. **PROCEDURE:**

1. Initiating first reinfusion:
   a. Uncoil the blood bag and tubing. Hold the blood bag tubing so that it forms a half loop at the base of the reservoir while the bag is below the level of the reservoir.
   b. Fully depress and hold down the release lever on top of the Constavac unit to transfer blood into the blood bag.
      i. 75 - 100 mL of blood will automatically remain in the reservoir.
   c. When transfer is complete, release the lever and use slide clamp to clamp off the blood bag tubing as close to the blood bag as possible.
   d. Once the lever is released, the red vacuum indicator will become inverted and regain constant negative pressure.
   e. Reinfuse utilizing the standard blood administration tubing set and a forty (40) micro aggregate blood filter.
   f. Record the time and amount of blood reinfused in **EHR**~~Cerner~~.
   g. Repeat the above process for further reinfusion when the drainage has reached 200 - 300 mL of blood within the six (6) hour time frame.

03/24Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/12, 08/17, **01/23**	12/12, 09/17, **01/23**	12/20, 09/17, **02/23**	12/17, **02/24**	n/a	01/18, **02/24**		02/13, 02/18, **n/a**	02/13, 02/18

~~g.~~**h. If less than 100 mL blood collected within 4 hours, discard the system or use the system for drainage only.**

2. Wound Drainage:
   a. Six (6) hours after initiation of system discontinue blood tubing and reinfusion portion of the Constavac system.
   b. Cut the reinfusion tubing approximately two (2) inches from the reservoir, discard bag and blood tubing in a red bio hazardous waste bag and cap the end of the tubing using red cap.
   c. Measure wound drainage output directly on the reservoir. Mark the time and amount of output on the canister and record in **EHR**~~Cerner~~.
3. Change the reservoir when the air filter becomes saturated, as necessary to maintain system, or when canister is ¾ full.
   a. Using aseptic technique, clamp evacuator tubing on each side of the quick connect.
   b. Twist quick connect to separate evacuator tubing from the canister.
   c. Discard Y-connector portion of evacuator tube from the new unit.
   d. Attach quick connect of the new unit to quick connect of evacuator tube attached to the patient.
   e. Set the vacuum level at prescribed setting, and unclamp tubing.
   f. Ensure that vacuum indicator is inverted.

D. **REFERENCE(S):**

1. **CBC II Constavac Blood Conservation System Operating Instructions. (7/2019) Retrieved January 17,2023 from www.3TMedical.com/wp-content/uploads/2019/11/0225-028-707-cbc-ifu-rev-v-1.pdf**
~~1. CBC II Constavac Blood Conservation System Operating Instructions. (2011) Retrieved November 2012 from www.stryker.com/stellent/gourp/public/documents/web_content/141262.pdf.~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ELECTROCAUTERY MACHINE SETUP, USE AND SAFETY**
Purpose:	To outline nursing responsibilities in the set-up and safe operation of the electrocautery machine.
Equipment:	Electrocautery machine Adult dispersive electrode (grounding pad) Safety holster Cautery pencil (hand activated) and accessory tip(s) Foot pedal – Monopolar Foot pedal – Bipolar Scratch pad

A. **PROCEDURE:**

1. The electro surgery unit (ESU), dispersive electrode, and active electrode selected for use shall meet the following performance and safety criteria:
   a. Use according to manufacturer's instructions for use (IFU).
   b. Design shall minimize unintentional activation.
   c. Cord shall be of adequate length and flexibility.
   d. The machine shall be inspected by the surgical/procedural team before each use.
   e. The ESU shall be appropriately grounded for each use.
   f. The ESU and all reusable parts shall be cleaned according to manufacturer's IFU.
   g. Personnel shall check the entire circuit if higher than normal power settings are requested during the surgical procedure.
   h. Each ESU shall be assigned an identification number and shall have routine scheduled preventive maintenance performed, per Engineering Policy: Preventive Maintenance. Ensure the electrocautery machine has a current Bio-Medical Engineering Preventative Maintenance (PM) sticker.
   i. Position the machine near sterile field. The machine, cord, and accessories shall be kept away from fluids and protected from spills.
      i. Containers of liquids should not be placed on energy-generating devices, as liquids may enter the device and cause unintentional activation, device failure, or an electrical hazard.
      ii. Foot pedal accessories should be encased in a fluid-resistant cover when there is potential for fluid spills.
2. Personnel shall demonstrate competency with the ESU prior to use:
   a. Personnel shall be instructed in the proper operation, care and handling of the ESU before use.
   b. The device manufacturer's IFU shall be readily available to users.
3. Follow fire safety precautions while using an ESU, per Patient Care Services (PCS) procedure Fire Prevention and Management in Invasive Procedure Areas.
4. The ESU, active electrode, and dispersive electrode shall be used in a manner that reduces the potential for injury, including the following safety measures:
   a. Do not use in the presence of flammable agents (alcohol-based prep solutions and other flammable agents must be allowed sufficient time to dry and fumes to dissipate before draping and/or use of an ESU).
   b. Use caution during head and neck surgery when using an active electrode in the presence of combustible anesthetic gases.
   c. Test safety features (i.e., lights, activation sounds) before each use.
   d. Check the cord, plug and footswitch for integrity before each use.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/08, 04/11, 01/13, 07/18, 08/23	02/11, 01/13, 08/18, 02/19, 09/23	03/11, 1/13, 09/18, 03/19, 10/23	04/19, 02/24	n/a	11/13, 05/19, 02/24	06/19 03/24	03/11, 2/14, n/a	04/11, 2/14, 06/19

e. Verbally confirm the power settings with the operator before activation, and operate at the lowest power settings possible to achieve the desired surgical effect.
f. Plug the ESU into an isolated electrical circuit.
g. Do not place other electrical equipment on top of or immediately next to the ESU. Allow space between the ESU and other electrical equipment, to avoid interference and potential inadvertent activation of the machines.
h. Sponges used near the active electrode tip should be moist to prevent unintentional ignition.
i. Electrosurgery should not be used in the presence of gastrointestinal gases.
j. Electrosurgery should not be used in an oxygen-enriched environment.
    i. The lowest possible oxygen concentrations that provide adequate patient oxygenation should be used.
    ii. Surgical drapes should be arranged to minimize the build-up of oxidizers under the drape.
    iii. The active electrode should be used as far from the oxygen source as possible.

5. Select and use a dispersive electrode (i.e., grounding pad) according to manufacturer's IFU.
    a. Inspect the grounding pad for damage prior to use.
    b. Never cut pad to fit or alter grounding pad in any way.
    c. Never use grounding pad when only bipolar cautery is being used.
    d. Open grounding pad package as close to the time of use as possible and confirm the manufacturer's expiration date has not passed. The longer the pad package is open, the greater the potential for drying of the dispersive electrode's adhesive and conductive gel.
6. Select grounding pad site.
    a. Place the grounding pad after the patient is in the final position for surgery/procedure.
    b. Ensure the grounding pad site is clean and dry, over a large, well-perfused muscle mass, intact skin, and as close to the operative site as possible.
    c. Ensure grounding pad maintains uniform contact with the patient's body throughout the procedure.
    d. Metal jewelry (including body piercings, subdermal implants, and transdermal or microdermal implants) that is between the active and dispersive electrode should be removed.
    e. Place the grounding pad away from a warming device whenever possible.
    f. AVOID the following areas when selecting a site for grounding pad placement:
        i. Over excessively hairy areas.
        ii. Over scar tissue
        iii. Over metal implants
        iv. Over bony prominences and potential pressure points
        v. Over skin folds
        vi. Wet areas (pooled fluids)
        vii. Areas distal to tourniquets
        viii. Over tattoos, which may contain metallic dyes
7. The following corrective measures shall be performed for poor contact of a single use electrode:
    a. Apply a new grounding pad
    b. Remove oil, lotion, moisture or prep solution
    c. Remove excessive hair
    d. Change sites
    e. Never use tape to hold the single-use dispersive electrode in place.
    f. If the patient is repositioned intraoperatively, the nurse should verify that the dispersive electrode is in full contact with the patient's skin.
8. If two ESU's will be used simultaneously during a procedure, a dispersive electrode should be used for each ESU.
    a. The dispersive electrodes should be placed as close as possible to the surgical site.
    b. The dispersive electrodes should not overlap.

c. The dispersive electrodes should be placed equidistant from the surgical site when it is a single site.

9. Plug grounding pad into cautery machine and turn on machine, per manufacturer's IFU.
   a. Adjust the volume to ensure audible alerts when the cautery is in use.
   b. Ensure connections are intact, clean, and make effective contact with the ESU.
10. The active electrode shall:
   a. Fasten directly in the ESU in a stress-resistant receptacle (adapters shall be manufacturer approved and not compromise safety features)
   b. Be inspected on the field for damage prior to use.
   c. Be inspected in a clean, dry, well-insulated safety holster when not in use, and used according to manufacturer's IFU.
   d. Be impervious to fluids.
   e. Be disconnected from the ESU if allowed to drop below the sterile field.
   f. Have a tip that is secure and easy to clean, and the tip shall never be altered, including cut, bent, or used with an insulating sheath made from inappropriate materials (i.e., rubber catheters).
   g. Be cleaned whenever there is visible eschar, which impedes the desired current flow, causing the entire unit to function less effectively and serving as a fuel source for fire.
11. The ESU shall be used with foot pedal or hand-control forceps according to manufacturer's IFU.
12. If an active monopolar electrode is being used in a fluid-filled cavity, the fluid used should be an electrically inert, near isotonic solution (i.e., sorbitol), unless the equipment manufacturer's written directions for use instruct otherwise.
13. Set ESU with desired power settings.
14. Adjust settings per physician preference.
   a. Refer to manufacturer's IFU for adjusting
15. Energy-generating device cords should be secured to the sterile drapes with a plastic or other non-conductive, non-piercing device, in a manner which does not crush or damage the cord. Do not secure ESU cords to drapes with a metal instrument.
16. Be aware of potential patient safety hazards associated with implanted electronic device (IED) (i.e., pacemaker, implantable cardioverter defibrillator [ICD], implantable hearing devices, implantable infusion pumps, deep brain, vagal nerve, or spinal cord stimulator) and take precautions to protect the patient from injury:
   a. Patients with pacemakers shall have continuous electrocardiogram (ECG) monitoring when an ESU is being used.
   b. Additional precautions for patients with pacemakers include, but are not limited to:
      i. Make the distance between the active and dispersive electrode as short as possible, and place both as far from the pacemaker as possible.
      ii. Ensure that the current path from the surgical site to the dispersive electrode does not pass through the vicinity of the heart.
      iii. Keep all ESU cords away from the pacemaker and the leads.
      iv. Have a defibrillator available.
      v. Check with the pacemaker's manufacturer regarding its function during the use of an ESU.
   c. Manage ICD's according to manufacturer's IFU and Surgical Services Policy: Patients with AICD Implant.
17. After completion of the case, turn off the ESU, dispose of single use items appropriately, clean all reusable parts to the ESU, inspect accessories and parts for damage, function and cleanliness, and carefully remove the dispersive electrode pad from the patient by peeling it back slowly.
18. Documentation shall include:
   a. Type of ESU
   b. ESU identification number
   c. ESU settings (minimum and maximum ranges)
   d. Location of dispersive electrode

e. Description of skin at dispersive electrode site pre- and post- procedure
f. Lot number of dispersive electrode

19. If injury occurs related to the ESU, the event must be reported to the manufacturer and/or the Food and Drug Administration (FDA) to comply with the Safe Medical Devices Act (refer to Administrative Policy: Equipment Medical Device Reporting Sequester - 201).
    a. Immediately remove the ESU from service.
    b. Send the ESU, active and dispersive electrodes, and their packaging to Biomedical Engineering Department.
    c. Enter a work order.
    d. Complete an incident report, including the ESU identification number and event information.

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

1. Administrative District Operations Policy: Equipment Medical Device Reporting Sequester 8610-201
2. Engineering Policy: Preventive Maintenance

C. **REFERENCE(S):**

1. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Emergency Cart (Crash Cart), Cardiopulmonary Arrest**
REVISION DATE:	**06/03, 10/04, 11/06, 10/07, 06/08, 08/09, 08/12, 07/16, 03/19, ~~04~~12/22**		

Patient Care Services Content Expert Approval:	**~~09/22~~10/23**
Clinical Policies & Procedures Committee Approval:	**~~10/22~~01/24**
Nursing Leadership Approval:	**~~11/22~~02/24**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee Approval:	**~~11/22~~02/24**
Administration Approval:	**~~12/22~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **POLICY:**

1. Emergency Carts (crash carts) shall be checked at least daily for integrity and expiring products by a licensed healthcare provider or designee on the unit. Verification of the crash cart checks will be documented by date and signatures in a logbook kept on top of the cart.
2. The licensed healthcare provider or designee checking the crash cart will ensure missing or expired items are replaced immediately. If items cannot be replaced in a timely manner, the crash cart should be replaced by the Sterile Processing Department (SPD).
3. Crash carts shall be stored in secured locations.
4. A crash cart may be left on a unit that is closed if properly secured.
5. Crash carts secured on a closed unit do not require checking until the unit is re-opened. A licensed healthcare provider or designee will write "Unit Closed" in the logbook for the dates when the unit was closed.
6. SPD shall immediately replace any cart used during a Code Blue~~, Code Caleb~~ or Code Pink with an Emergency Cart that has been checked for integrity and expiring products.
   a. The replacement cart shall be deemed ready for use upon arrival to the unit.
   b. After a code, a licensed healthcare provider or designee shall ensure the crash cart and the contents of the crash cart are secured per Securing Emergency Cart Guidelines.
   c. Contact SPD to pick up the used crash cart.
   d. Place the used locked crash cart in a location that is visible at all times to a healthcare provider until it is picked up by SPD.

~~d.~~7. If expired items or lock discrepancy identified during a crash cart check, contact SPD for a replacement cart.

~~7.~~8. The Code Blue Committee shall make recommendations for content changes based on code evaluations and recommendations from the American Heart Association.

B. **PROCEDURE FOR CHECKING CODE BLUE, CODE PINK AND CODE CALEB CRASH CARTS:**

1. All documentation of cart checks will be completed on the department specific Emergency Equipment/Supplies Checklist. All fields must be complete by the healthcare provider checking the chart, documenting their signature on the checklist form.
2. Implement the following when completing emergency cart checklists
   a. Check the integrity of all locks/tags. If any lock/tag is broken, call SPD to replace the cart.
      i. Adult cart document:

1) Lock number on the locking bar on the crash cart.

ii. Pediatric cart document:
1) Medication drawer expiration date and lock number
2) Intravenous (IV) drawer expiration date and lock number
3) Red Airway Bag expiration date and lock number

iii. Neonatal cart document:
1) Medication drawer expiration date and lock number
2) IV drawer expiration date and lock number

b. Check the medication sticker and document medication expiration date.
i. Ensure the sticker number matches the lock number. ~~Notify Pharmacy of **SPD to replace the crash cart** if the following is present:~~
~~1) Any lock number discrepancies.~~
~~2) Expired medications.~~

c. Check non-medication supply sticker(s) and document the expiration dates.

d. Check IV solution sticker and document expiration date.
~~i. Notify SPD if any supplies are expired.~~

e. Presence and function of suction equipment (except for neonatal cart).
i. Suction unit shall be checked unplugged for adequate function.
ii. Battery level of suction unit will be checked while unit is unplugged to ensure adequate charge.

f. Presence of Resuscitation Code Record and Evaluation/Debriefing form on clipboard appropriate to type of cart (adult, pediatric, neonatal).

g. Resuscitation algorithms appropriate for type of cart (adult, pediatric, neonatal).

h. The inventory lists are available on the cart.
i. The list is maintained and updated by SPD.

i. **Appropriate supply**~~Six pack~~ of electrocardiogram electrodes.

j. Presence of resuscitation bag (Ambu) and supplies appropriate for type of cart (adult, pediatric, neonatal).
i. Check the oxygen mask to ensure the seal is sufficiently inflated.

k. Presence of oxygen tank (except for neonatal cart).
i. Replace tank if gauge reads 1000 p.s.i. (pounds per square inch) or less.

l. Presence of extension cord/multi-outlet cord.

m. Presence of backboard (except for neonatal cart).

n. For Pediatric/Broselow Cart only:
i. Scissors
ii. Two (2) Alaris Pumps

3. For units with Automatic External Defibrillators (AED) see Patient Care Services Policy: Automated External Defibrillator Checks, Philips
a. replace the pads immediately.

C. **FORM(S):**

1. Tri-City Medical Center Crash Cart Checklists – Age Specific

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

1. Patient Care Services (PCS) Policy: Rapid Response Team
2. PCS Procedure: Defibrillator Checks
~~3. PCS Procedure: Malignant Hyperthermia Management~~
~~4.~~3. Securing Emergency Cart Guidelines

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**EPIDURAL OR INTRATHECAL CATHETER INFUSION IN THE NON-LABORING PATIENT**
Purpose:	To outline nursing management for the adult inpatient with an indwelling epidural or intrathecal catheter for narcotic administration.
Equipment:	Portless Epidural/Intrathecal Administration Set Transparent dressing Alaris infusion pump Epidural/Intrathecal insertion kit Epidural/Intrathecal anesthetic/analgesic solution as ordered by anesthesiologist Blood pressure cuff Pulse oximeter Oxygen delivery equipment & suctioning equipment readily available at bedside Narcan® (Naloxone) Kelly clamp Narcotic administration record/Assessment Record Medication lock box Medication lock box key

A. **DEFINITION(S):**

1. Epidural Infusion: A continuous infusion into the epidural space.
2. Epidural Bolus: An intermittent injection via the indwelling epidural catheter.
3. Intrathecal Infusion: A continuous infusion into the intrathecal space.
4. PCEA infusion: patient controlled epidural analgesia.

B. **POLICY:**

1. The anesthesiologist or physician and the assigned Registered Nurse (RN) share the responsibility for the observation and monitoring of patients receiving epidural or intrathecal anesthesia.
2. The pharmacy department is responsible for the preparation of the epidural anesthetic/analgesic solution.
3. Only the anesthesiologist or physician may insert the epidural or intrathecal catheter. The lot number and brand of the kit will be documented on the procedure form by the nurse assisting with the procedure.
   a. The nurse assisting with the procedure will provide positioning assistance and emotional support to the patient during the epidural initiation procedure.
4. The patient will not be transferred to the next level of care until the epidural setup is connected, and the Alaris pump has been programmed and verified by two (2) RNs.
5. All epidural infusions must be on a dedicated infusion pump with only one module attached, and the intravenous (IV) solution contained in a medication lock box.
6. Electronic channel label shall be selected via guardrails or channel labels.
7. Ensure patient has IV access.
   a. IV access shall be maintained for at least eight (8) hours after last dose of epidural medicine or discontinuance of epidural/intrathecal catheter.

C. **PROCEDURE :**

1. Obtain physician's order for epidural or intrathecal solution.
2. Verify correct patient per Patient Care Services (PCS) Policy: Identification, Patient
3. Set-up:
   a. Bag Infusion Delivery:

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
04/07, 06/09, 07/15, 01/16, 08/17, **02/23**	07/11, 08/15, 05/16, 11/18, 02/19, **02/23**	08/11, 05/16, 03/19, **03/23**	10/16, 05/19, **10/23**	02/07, 11/16, 05/19, **02/24**	10/11, 11/16, 06/19, **02/24**	07/19, **03/24**	11/11, 01/17, n/a	11/11, 01/17, 08/19

i. Spike the epidural/intrathecal solution, or bag with the yellow striped portless tubing after verification of correct dose with 2nd RN, prime the tubing, and thread the tubing through the epidural pump according to manufacturer's instructions.
   1) The epidural will be connected to the infusion tubing and Alaris pump on the sterile field if medication is available.
ii. Attach the medication lock box.
iii. Lock the box containing the epidural/intrathecal solution with the medication lock box key stored in the Pyxis.

b. Syringe Delivery Device for Patient Controlled Epidural Analgesia (PCEA)
   i. ~~———~~

4. Initiation:
   a. Program the pump, using Guardrails, to the dosing parameters ordered by the anesthesiologist or physician with 2nd RN to verify settings.
      i. For PCEA, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist or physician (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by 2 RN's.
   b. Start the infusion.
   c. Activate the lockout on the Alaris pump controls, located on the back of the infusion device.
   d. Return the medication lock box key to Pyxis
   e. Document on electronic health record (EHR) with two (2) RNs.
5. Maintenance:
   a. Administration of bolus or increase:
      i. Boluses must be given through infusion pump, do not break the closed system.
      ii. Program infusion rate on pump per anesthesiologist or physician's order verified with second RN.
      iii. After the bolus, reprogram pump to continuous infusion rate as ordered by anesthesiologist or physician. Verify with 2nd RN.
      iv. Document on EHR
   b. Instruct patient, significant other/family:
      i. Type of pain management.
      ii. Frequency and nature of monitoring:
      iii. Avoid touching or manipulating catheter or tubing.
      iv. Avoid excessive moving around or overstretching upper extremities.
      v. Do not get insertion site wet.
      vi. Notify RN if catheter is accidentally removed or if any part becomes disconnected.
      vii. Notify RN if signs of nausea, vomiting, pain, itching, pruritis, severe headache, neck pain, backache, bladder fullness, numbness or tingling or decreased movement or strength in lower extremities.
   c. Changing Infusion Bag:
      i. Hang pre-mixed solution containing the same medication as ordered by the anesthesiologist/physician after verifying with a 2nd RN.
   d. Changing the Syringe:
      i. Insert the pre-mixed syringe containing the same medication as ordered by the anesthesiologist/physician after verifying with a 2nd RN.
6. Assessment:
   a. Assess for complications that may be associated with epidural initiation.
      i. Local anesthetic toxicity: Assess for drowsiness, light-headedness, tinnitus, circumoral paresthesia, metallic taste in mouth, slurred speech, blurred vision, unconsciousness, cardiac dysrhythmia, and cardiac arrest. Notify anesthesiologist or physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.

ii. High Spinal: Assess for numbness or weakness of the upper extremities, dyspnea, weak speech or inability to speak, apnea and loss of consciousness. Notify anesthesiologist or physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
iii. Hypotension: Position patient in lateral position, notify anesthesiologist or physician, and administer intravenous fluid bolus if ordered.

b. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate every one (1) hour until epidural or intrathecal catheter is discontinued.
c. Assess epidural or intrathecal catheter or tubing:
i. Every four (4) hours, verify the portless tubing is connected to the epidural or intrathecal catheter.
ii. Every shift, verify catheter, infusion tubing, epidural or intrathecal pump, and epidural or intrathecal solution are properly labeled.
d. Assess insertion site:
i. Every four (4) hours, verify catheter site is clean, dry and intact without signs of edema, drainage or infection.
e. Monitor sensory and motor function of lower extremities every four (4) hours, and before and after catheter removal.
f. Monitor for the following possible side effects every four (4) hours, and see physician orders for appropriate intervention as needed:
i. Change in level of consciousness
ii. Nausea and vomiting
iii. Itching, pruritis
iv. Urinary retention
v. Loss of motor function, strength, and sensation of lower extremities
vi. Before and after ambulation
vii. Before and after epidural catheter removal
g. If disconnection from the catheter tubing is suspected, cover with sterile gauze, and notify Anesthesiologist. Do not use alcohol or attempt to reconnect.

D. **PROCEDURE FOR SYRINGE DELIVERY DEVICE FOR PCEA:**

1. Obtain physician's/AHP's order for epidural or intrathecal solution
2. Obtain solution filled syringe from Pharmacy and connect the yellow striped portless tubing to the syringe after verifying correct dose with second (2nd) RN. Prime tubing.
3. For PCEA, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist/ or physician (AHP) (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by two (2) RN's.
4. Insert the syringe into the Alaris pump
5. Program the Alaris pump, using Guardrails, to the dosing parameters ordered by the physician/AHP and verify settings with 2nd RN.
6. Start the infusion.
7. Engage the lockout feature on the Alaris pump.
8. Return the medication lock box key to Pyxis.
9. Document on the electronic health record (EHR) with two RNs for Patient controlled anagesia (PCAs) and epidurals.
10. Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

E. **REMOVAL OF EPIDURAL OR INTRATHECAL CATHETER:**

1. Verify written physician order to remove catheter.
2. Review the patient's coagulation status and ensure the results are within normal limits.
   a. Check prothrombin time (PT) levels and platelet level where applicable. For elevated PT levels, or platelet level less than 100,000, consult Anesthesiologist prior to removal.

b. Record neurological exam of the lower extremities every one (1) hour times two (2), every two (2) hours times two (2), every four (4) hours times two (2) after removal of the catheter.

3. Place patient in relaxed position.
4. Assess patient for back pain, back tenderness and baseline motor strength and sensation prior to removal of the catheter.
5. Assess site for hematoma, drainage and signs of infection.
6. Stop infusion and clamp tubing. Document final volume readings.
7. Perform hand hygiene and don gloves.
8. Remove dressing while maintaining pressure on tubing just above insertion site. Do not use alcohol. (Alcohol is neurotoxic to epidural space.)
9. Gently and steadily remove catheter with one slow motion while holding 2x2 gauze over the site. If patient develops pain or parasthesia or resistance is met, stop procedure, place a sterile dressing over site to secure epidural or intrathecal line, and notify anesthesiologist or physician.
10. Verify catheter tip is intact and rounded once catheter is removed.
11. If tip is missing:
    a. Notify physician.
    b. Place the catheter with the missing tip in a specimen bag and label with the patient's name, date of removal
    c. Give the specimen bag with the tip to the **Nurse Leader**~~Assisted Nurse Manager (ANM)~~**/designee**~~relief charge~~.
    ~~c.~~**d. The Nurse Leader will ensure an incident report is entered in the electronic reporting system. The specimen bag with missing tip will be sent to the Risk Management department.**
12. Place sterile dressing over the area and apply pressure for at least two (2) minutes.
13. Evaluate patient's motor strength and sensation. Notify physician for decreased motor strength and/or sensation.
14. Document procedure and patient response.
15. Waste unused medication per the PCS Procedure: Wasting Narcotics, Documentation in the Pyxis Machine.
16. Return lock box and Alaris pump to sterile processing department (SPD).
17. Return medication lock box key to unit Pyxis.

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

1. Patient Care Services Policy: Identification, Patient
2. Patient Care Services Procedure: Automated Dispensing Machine

G. **REFERENCE(S):**

1. Cohen, S.P. & Dragovich, A. (2007, December). Intrathecal anesthesia. *Anesthesiology Clinics*, 25(4). Retrieved http://www.mdconsult.com
2. Grant, P.J. & Wesorick, D.H. (2008, March). Perioperative medicine for the hospitalized patient. *Medical Clinics of North America*, 92(2). Retrieved from http://www.mdconsult.com
3. Elesvier Clinical Skills. Epidural Catheter Insertion, Management and Removal. Retrieved September 18th, 2017.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**GOWNING & GLOVING**
Purpose:	To outline the process of gowning and gloving for surgery and other invasive procedures. Surgical gowns and gloves are worn to protect patients and surgical team members from transmission of pathogens by establishing a barrier to minimize the passage of microorganisms, body fluids, and particulate matter between sterile and unsterile areas.
Equipment:	Sterile gown and gloves

A. **POLICY:**

1. Surgical gowns and gloves shall be selected for use based on procedure-related requirements, end user requirements and preferences, and patient-related requirements.
2. Surgical gowns and gloves must provide a barrier and should be resistant to tears and punctures.
3. Barrier materials used for surgical gowns should be as lint-free as possible.
4. Scrubbed team members should perform surgical hand antisepsis before donning sterile gowns and gloves.
5. Scrubbed team members should don sterile gowns and gloves in a sterile area away from the main instrument table.
6. Scrubbed team member's hands and arms should be completely dry before donning a sterile gown.
7. Scrubbed personnel should select gowns of appropriate size and sleeve length.
   a. Gowns shall be of adequate size to cover completely in the back and sleeves of adequate length to prevent cuff exposure outside the glove.
   b. Gowns with excessive size or sleeve length increase risk of contamination.
8. The front of a sterile gown is considered sterile from the chest to the level of the sterile field. Gown sleeves are considered sterile from two inches above the elbow to the cuff, circumferentially.
   a. The neckline, shoulders, and axillary areas of the surgical gown are areas of friction and are not considered an effective microbial barrier, therefore are considered contaminated.
   b. Sleeve cuffs are considered unsterile when scrubbed personnel's hands pass through and beyond the cuff.
   c. The back of the surgical gown cannot be constantly monitored and is considered unsterile.
9. Scrubbed personnel should inspect gloves for integrity after donning, before contact with the sterile field, and throughout use.
10. The closed assisted gloving method should be used to glove team members during initial gowning and gloving.
11. Scrubbed team members should wear two pairs of surgical gloves, one over the other, during surgical and other invasive procedures with potential for exposure to blood, body fluids, or other potentially infectious materials.
    a. When double gloves are worn, a perforation indicator system should be used (i.e., a colored pair of surgical gloves worn beneath a standard pair of surgical gloves).
12. Contaminated gloves should be changed as soon as possible. The preferred method of changing contaminated gloves is assisted gloving, where one member of the sterile team assists another. If this method is not feasible, open gloving must be used to change contaminated gloves. If it is not possible to change gloves at the moment the break in technique occurs, a new glove may be placed over the contaminated/damage glove until it can be changed.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/94, 01/13 04/18, **08/23**	09/09, 01/13, 05/18, **09/23**	11/09, 01/13, 05/18, **10/23**	01/19, **02/24**	n/a	01/10, 05/13, 02/19, **02/24**	03/19, **03/24**	02/10, 6/13, n/a	02/10, 06/13, 03/19

B. **PROCEDURE:**

1. Gowning:
   a. Scrubbed personnel:
      i. Open sterile gown and gloves on surface away from the main instrument table.
      ii. Perform surgical hand antisepsis
      iii. If a wet scrub was performed, dry hands and arms with a sterile towel. Be careful not to contaminate the sterile field or towel by dripping water onto the sterile field or touching the towel to scrub attire or unsterile surroundings.
      iv. Grasp the sterile gown, touching only the inside surface of the gown, step back away from sterile field and allow the gown to unfold completely.
      v. Insert arms into respective armholes of the gown, keeping hands inside the sleeves, above the cuffs and keeping arms at shoulder height.
   b. Circulating nurse/designee:
      i. Pull gown over the shoulders of scrubbed personnel, touching only the inside of the gown.
      ii. Secure Velcro tabs and ties at the neckline and waist.
2. Closed Gloving:
   a. Scrubbed personnel
      i. Grasp the folded cuff of the glove, keeping hands inside the cuff of the gown.
      ii. Place the glove upside down on enclosed hand with the fingers pointing toward the body, and keeping thumb lined up with the thumb of the glove.
      iii. Grasp inside the glove cuff with the enclosed thumb.
      iv. With opposing enclosed hand, stretch the glove up and over the sleeve cuff.
      v. Advance the hand through the cuff of the sleeve, keeping the sleeve cuff completely covered by the glove.
      vi. Repeat for other hand.
      vii. Pass gown tab with attached tie to another member of the team.
   b. Circulating nurse/designee:
      i. Hold ~~car~~ **gown tab** attached to sterile tie while scrub person pivots. Do not touch the sterile tie.
      ii. Hold ~~card~~ **gown tab** securely while scrub person pulls sterile tie away.
      iii. Scrubbed personnel will tie gown at the waist.
3. Open Gloving:
   a. Scrubbed personnel wearing a sterile gown shall:
      i. Extend hands through cuff of the sterile gown.
      ii. Grasp the inner side of the glove cuff with the opposite hand. Do not touch the outside of the glove.
      iii. Insert hand into glove and pull glove up over the entire cuff of the gown.
      iv. Place gloved hand under the cuff of the opposite glove, lift and insert ungloved hand into glove, pull the glove over the hand completing covering the gown cuff.
4. Changing a contaminated gown:
   a. Circulating nurse shall untie scrub's gown and remove. Do not touch bare arms.
   b. Scrubbed personnel repeat entire gowning and closed gloving procedure.
5. Gowning & gloving other team members:
   a. Scrubbed personnel
      i. Pass a sterile towel to newly scrubbed team member, if wet scrub performed. Do not contaminate self by touching bare hands or arms of scrubbed team member.
      ii. Open gown, cuff hands under the neckline of the sterile gown, allow to completely unfold, and place over outstretched arms of team member.
      iii. Release the gown, allowing the circulating nurse to pull the gown over the shoulders of the scrubbed team member and secure at neckline and waist.
      iv. Grasp sterile glove, palm facing the ungloved team member, thumb to thumb.

v. Stretch cuff open and grasp firmly while team member advances hand into the glove.

vi. Repeat with other glove, then turn gown of team member, if a wrap–around gown.

C. **REFERENCE(S):**

1. Rothrock, J. ~~(2015).~~ **(2019)** Alexander's Care of the Patient in Surgery, ~~15~~**th 16th** Edition. St. Louis, MO: Elsevier., **pgs. 92-27**
2. ~~Conner, R.~~**Kyle, Erin DNP, RN, CNOR, NEA-BC** ~~(2017).~~ **(2023) AORN** Guidelines for Perioperative Practice, **Sterile Technique,** ~~2017 Edition.~~ Denver, CO., **pgs. 1016-1056**; ~~Association of PeriOperative Registered Nurses.~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HIGH-LEVEL DISINFECTION**
Purpose:	To disinfect semi-critical patient care equipment between uses
Equipment:	Personal protective equipment (gloves, eye protection, impervious gown, face shield or simple surgical mask) Enzymatic/detergent Sponge or soft, lint-free cloth Brush High-level disinfectant (i.e., Cidex ortho-phthalaldehyde [OPA]) Tap Water Sterile Water 70% isopropyl alcohol or equivalent

A. **DEFINITION(S):**

1. Critical items: According to Spaulding classification system, items that enter sterile tissue, including the vascular system (i.e., surgical instruments, implants and needles). Critical items should be sterile when used.
2. Semi-critical items: According to Spaulding classification system, items that come in contact with non-intact skin or mucous membranes (i.e., vaginal and rectal probes,ultrasound probes used during percutananeous guided procedures, respiratory therapy equipment, bronchoscopes, gastrointestinal endoscopes and accessories). Semicritical items should be processed by sterilization, or, at a minimum, high-level disinfection.
3. Non-critical items: According to Spaulding classification system, items that come into contact only with intact skin (i.e., tourniquets and blood pressure cuffs). Non-critical items should receive intermediate or low-level disinfection.
4. High-Level Disinfection (HLD): A process that deactivates all types of microorganisms with the exception of bacterial spores and prions.
   a. Used for reprocessing reusable semi-critical items.
   b. May be accomplished via an automated reprocessor or manual soaking in a high-level disinfecting agent. The method of HLD for each piece of equipment shall be selected based on manufacturer's instructions for use (IFU).
   c. The effectiveness of HLD depends on effective pre-cleaning, manual cleaning, and rinsing to decrease the organic load and microbial content of the equipment/endoscope, drying after rinsing to avoid dilution of HLD agent, and proper preparation and use of the disinfectant in accordance with the manufacturer's IFU.
5. Pre-Cleaning: Pre-cleaning removes organic material (i.e., blood, body fluids, body soil) and decreases the bioburden, making it much more likely that subsequent reprocessing steps will be successful. Pre-cleaning should be performed at the point of use, before bioburden has an opportunity to dry and before complete decontamination.
6. Leak Testing: Testing to detect damage to the interior channels and exterior surfaces of an endoscope that can lead to inadequate disinfection and further damage. Leak testing is done before immersion of the endoscope in reprocessing solutions to minimize damage to parts of the endoscope not designed for fluid exposure.

B. **POLICY:**

1. With the exception of pre-cleaning, reprocessing of endoscopes should not be conducted in patient care areas because of the risk of patient exposure to contaminated surfaces and devices.

Department Approval	Clinical Policies & Procedures	Nursing Leadership	Infection Control Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/06, 05/07, 06/09, 09/11, 08/12, 04/15, 06/17, 03/20, 08/23	08/12, 06/15, 12/16, 07/17, 03/20, 10/20, 09/23	08/12, 07/15, 01/17, 07/17, 04/20, 12/20, 10/23	07/15, 04/17, 10/17, 03/20, 04/20, 03/21, 01/24	10/12, 07/15, 05/17, 11/17, 05/20, 03/21, 02/24	06/20, 04/21, 03/24	11/12, 08/15, 01/18, n/a	12/12, 08/15, 01/18, 06/20, 04/21

2. Gloves should be worn during all phases of endoscope handling, including moving clean scopes from storage to a procedure room, removing scopes from an automated endoscope reprocessor (AER), and taking the scope into storage.
3. Follow manufacturer's recommendations for maximum time to elapse between steps of pre-cleaning, cleaning, and HLD/sterilization. If the maximum allowable time is exceeded between steps, follow manufacturer's recommendations for delayed reprocessing.
4. Visual inspection is an essential step to make sure the equipment/endoscope is visibly clean. Endoscopes and reusable accessories should be visually inspected during all stages of handling and reprocessing, before, during and after use, in addition to during and after cleaning and before HLD.
5. The department leadership team has the responsibility to oversee the HLD process in their department with consultation from Infection Prevention.
6. The following staff with documented competency are authorized to perform HLD, including, but not limited to:
    a. Sterile Processing Department (SPD) Technicians
    b. Procedural Registered Nurses (RN's)
    c. Respiratory Therapists
    d. Equipment Respiratory Technicians
    e. Ultrasound Technicians
    f. Special Procedure Technicians
    g. Cardiovascular Technologists
    h. Endoscopy Technicians
    i. Radiology Technologist
    j. Surgery RN's
7. Education, Training, and Competency Validation:
    a. Initial:
        i. An orientation and training program will be provided to all staff prior to performing HLD. Clinical educators, clinical managers, or any other competent staff member will provide this training. Competency validation will be accomplished through individual return demonstration of skills. Records of training and competency validation will be maintained.
    b. Annual:
        i. All staff who perform HLD will complete an annual Computer Based Learning (CBL) module.
        ii. All staff who perform HLD will complete an annual competency.
            1) Additional training will be provided on an as needed basis

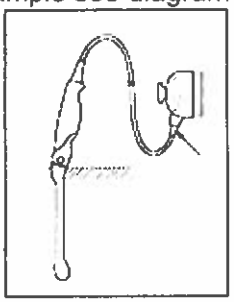
C. **PROCEDURE:**

1. PRE-CLEANING: Pre-clean equipment in the procedure room immediately after removal of the equipment or insertion tube from the patient and prior to disconnecting the endoscope from the power source, according to manufacturer's IFU. General guidelines for pre-cleaning include:
    a. Don personal protective equipment (PPE), including, at a minimum, gloves, eye protection, impervious gown, and face shield or simple surgical mask.
    b. Immediately after removing the equipment/endoscope from the patient, wipe the insertion tube with the wet cloth or sponge soaked in a detergent solution (commercially packaged or freshly prepared). Discard the cloth/sponge after use, according to manufacturer's IFU.
    c. Place the distal end of the endoscope into the appropriate detergent solution and suction the detergent solution through all channels, per manufacturer's IFU. Finish by suctioning air, according to manufacturer's IFU.
        i. Duodenoscopes/Echoendoscopes: Flush and manipulate the forcep elevator per manufacturer's IFU.
    d. Flush air and water channels per manufacturer's IFU.

e. Flush auxiliary water channel per manufacturer's IFU.
f. Detach the endoscope from the light source and suction pump.
g. Attach protective video caps where applicable.
h. Transport the soiled equipment/endoscope to the reprocessing area in an enclosed, puncture-resistant container with a Biohazard label.

2. LEAK TESTING: Leak test equipment/endoscope according to manufacturer's IFU. General guidelines for mechanical (wet) leak testing include:
   a. Remove suction valves, air water valves, and biopsy valves, according to manufacturer's IFU.
   b. Discard those parts that are designated as disposable. The endoscope must be completely disassembled so all surfaces may be reached for thorough cleaning, according to manufacturer's IFU.
   c. Attach the leak tester and pressurize the endoscope before submerging it in clear water, according to manufacturer's IFU.
      i. Never add detergent to water before or during leak testing. Detergent will obscure bubbles leaking from the endoscope and a leak may be missed. Follow manufacturer's IFU to determine if it is necessary to remove other detachable parts before leak testing.
   d. With the pressurized endoscope completely submerged, flex the distal portion of the endoscope in all directions, observing for bubbles. Check the insertion tube, distal bending section, and universal cord for bubbles coming from the interior of the endoscope, according to manufacturer's IFU.
   e. Remove the endoscope from the sink or basin. Turn off the leak tester. Disconnect the leak tester from the video cap. Allow the endoscope to depressurize. Ensure the video cap is secure and has not loosened with the removal of the leak tester. Continue with the reprocessing steps when the test is complete unless a leak is detected, according to manufacturer's IFU.
   f. Remove the endoscope from service if a leak has been identified or detected, and follow manufacturer's IFU for how to proceed.

3. MANUAL CLEANING: Manually clean equipment/endoscopes prior to automated/manual HLD or sterilization, according to manufacturer's IFU. General guidelines for manual cleaning include:
   a. Don PPE.
   b. Fill a sink or basin with freshly prepared solution of water and a medical grade, low-foaming, pH neutral detergent (with or without enzymes), per manufacturer's IFU.
      i. Dilute and use according to the detergent manufacturer's IFU.
      ii. Fresh detergent solution should be used for each item to prevent cross-contamination.
      iii. Low-foaming detergents are recommended such that the device can be clearly visualized during the cleaning process to preclude personnel injury and to allow for complete cleaning of lumen surfaces.
   c. Ensure the video cap is secure, if applicable. Immerse the equipment/endoscope.
      i. Exception: Non-immersible probes shall only be immersed up to the connector (for example see diagram below)



d. Wash all debris from the exterior of the equipment/endoscope by brushing and wiping the instrument while submerged in the detergent solution. The equipment/endoscope should be submerged in the detergent solution when performing all subsequent cleaning steps to prevent splashing of contaminated fluid and aerosolization of bioburden.
e. Use a small, soft brush to clean all reusable, removable parts, including inside and under the suction valve, air/water valve, and biopsy port cover and openings. Use non-abrasive and lint-free cleaning tools to prevent damage to the equipment/endoscope. It is recommended that single-use, disposable cleaning tools be used when possible.
f. Brush all accessible endoscope channels, as well as the body, insertion tube, and the umbilicus of the endoscope. Use a brush size compatible with each channel. All internal and external surfaces of the endoscope and its removable parts must be thoroughly cleaned, and all auxiliary channels (even if not used) must be brushed and flushed according to manufacturer's IFU.
g. Duodenoscopes have an elevator channel which is difficult to clean, requiring additional steps in all phases of reprocessing. Follow manufacturer's IFU for each specific endoscope model for additional steps at each phase of reprocessing.
h. After each passage, rinse the brush in the detergent solution, removing any visible debris before retracting and reinserting it.
i. Continue brushing until there is no debris visible on the brush.
    i. All brushes shall be disposable. Dispose of single-use brushes after each use.
j. Attach the endoscope manufacturer's cleaning adapters for suction, biopsy, air, and water channels. An automated pump may be used according to manufacturer's IFU for flushing, in lieu of manual flushing. Refer to manufacturer's IFU to determine if the automated pump is compatible with the endoscope.
k. Attach the manufacturer's cleaning adapters for special endoscope channels (i.e., elevator channel, auxiliary channel), according to manufacturer's IFU.
l. Flush all channels with the detergent solution to remove debris and soak the endoscope and its internal channels per the manufacturer's IFU, for the period of time specified by the detergent manufacturer's IFU.
m. Follow manufacturer's IFU for the recommended reprocessing time frame. If the time frame is not achievable, implement the manufacturer's procedures for delayed reprocessing.

4. RINSE AFTER MANUAL CLEANING: Thoroughly rinse the equipment/endoscope after cleaning, according to manufacturer's IFU.
    a. Thoroughly rinse the equipment/endoscope and all removable parts with clean water to remove residual debris and detergent.
    b. Purge water from all channels using forced air.
    c. Dry the exterior of the equipment/endoscope with a clean soft, lint-free cloth to prevent dilution of the HLD agent used in subsequent steps.
5. VISUAL INSPECTION: Inspect equipment for cleanliness and integrity, including all exterior surfaces of equipment and internal channels of endoscopes (using a borescope).
    a. Visually inspect for conditions that could affect the disinfection process (e.g., cracks, corrosion, discoloration, and retained debris).
    b. Repeat manual cleaning steps if equipment/endoscope is determined not to be visually clean.
    c. Remove damaged endoscopes and accessories from service for repair or disposal, according to manufacturer's IFU.
6. HIGH-LEVEL DISINFECTION: Perform HLD (manual or automated) according to manufacturer's IFU.
    a. Follow high level disinfectant manufacturer's IFU:
        i. Use Cidex OPA directly from the manufacturer's original container, no activation is required, per manufacturer's IFU.
        ii. Follow manufacturer's IFU for expiration dating:

1) Cidex OPA has a 14 day reuse life once it has been poured into a secondary container (soaking basin/tray).
2) Record the date Cidex OPA was poured into the secondary container and the expiration date on: the basin/tray, the lid(s) of the basin(s)/tray(s) and on the Cidex OPA Log Sheet for each basin/tray used.
3) Any Cidex OPA that remains unused in the manufacturer's original container is good for 75 days from the date the container is opened. Record the date the container was opened directly on the container.

b. High level disinfectants must be tested for minimum effective concentration (MEC) according to manufacturer's IFU prior to each use.
   i. Follow manufacturer's IFU for test strip expiration date. Cidex OPA Test Strips expire 90 days after the test strip container is opened.
      1) Label test strip container with expiration date.
      2) Tightly re-cap test strip bottle after each use.
   ii. Completely submerge the indicating pad of the test strip in the Cidex OPA.
   iii. Hold the test strip in the solution for 1 second, and then remove the test strip.
      1) Do not swirl the strip.
   iv. Remove excess solution from the test strip by standing the strip upright.
   v. Read the results in 90 seconds. Do not read past 90 seconds. Pad will be completely purple to indicate effective solution.
   vi. If any blue remains on the indicator pad apart from the top line, solution is ineffective and must be discarded.
   vii. Results of MEC testing (Pass or Fail) must be documented on the HLD log.
   viii. Cidex OPA test strips must be tested for efficacy each time a new container of test strips is opened. Repeat the quality control testing of the test strips at 30 days and 60 days, if the container is still in use. Results must be recorded on the Cidex OPA Log. Testing is completed as follows:
      1) Open new bottle of test strips and record lot # on Cidex OPA Log Sheet.
      2) Open a container of Cidex OPA.
      3) Dilute one part Cidex OPA solution with one part tap water.
         a) Example: one ounce Cidex OPA to one ounce tap water.
      4) Submerge 3 Cidex OPA test strips in undiluted Cidex OPA solution and 3 Cidex OPA test strips in the diluted Cidex OPA solution for 1 second. Remove the test strips and read the results in 90 seconds.
      5) The test strips that were placed in the full strength Cidex OPA should turn purple. The test strips in the diluted Cidex OPA will either remain the same or have an incomplete color change. Refer to the color chart.
      6) Record the test results on the Cidex OPA log sheet.
      7) If the test strips fail the test, repeat the test with fresh Cidex OPA solution and test strips from another bottle. If they fail, notify Materials Management. Return the test strips to Materials Management and re-order test strips.

b. HLD may be performed by the following methods:
   i. Automated Endoscope Reprocessor (AER)
      1) Follow manufacturer's IFU for HLD and AER operation.
      2) All channel adapters shall be used according to manufacturer's IFU.
      3) For duodenoscopes and echoendoscopes, follow manufacturer's IFU for disinfecting the elevator channel and positioning the elevator during HLD.
      4) Place valves and other removable parts into the soaking basin of the reprocessor. Unless the reprocessor has dedicated space for accessories, reprocess these items separately.

5) Set the machine according to manufacturer's IFU and allow it to complete all cycles/phases. If cycles/phases are interrupted, HLD cannot be ensured and the full cycle must be repeated.
6) If a final alcohol rinse cycle is not included in the automated reprocessor cycle, this step should be done manually, followed by purging all the channels with air until dry.
7) Remove endoscopes promptly from the AER after cycle completion. Do not allow endoscopes to sit in the AER for long periods, such as overnight.

ii. Hydrogen Peroxide-Based HLD Agent (i.e., Trophon) for endocavity probes or ultrasound probes used during percutaneous procedures according to manufacturer's IFU:
1) Don PPE.
2) Load the clean and dry probe into the Trophon Probe Reprocessor (EPR).
3) Ensure that the probe is secured high in the chamber with tip of probe above the embossed line.
4) Place the Trophon Chemical indicator into the indicator holder with red side facing up.
5) Close the chamber door.
6) Confirm that the probe is both clean and dry, if YES, press start.
7) At the end of the seven minute HLD cycle, Trophon screen will state "cycle complete remove and wipe the probe".
8) Don clean gloves.
9) Open the chamber door.
10) Remove the chemical indicator and check the chemical indicator chart on the chemical indicator carton. Discard the chemical indicator after verifying a positive reading.
11) Remove and wipe the probe using a dry single use cloth.
12) Close the chamber door.
13) Record the HLD cycle

iii. Manual HLD:
1) Temperature Recording:
   a) When the Cidex OPA has been poured into a secondary container, record (on Cidex OPA Log Sheet) the temperature each time the Cidex OPA is used. Temperature must be 68° F or higher for manual disinfection.
2) Perform MEC testing for high level disinfectant per manufacturers' IFU
3) Perform manual HLD according to manufacturer's IFU. Equipment/endoscopes must be purged with air and externally dried prior to immersion to minimize diluting the high level disinfectant.
4) Completely immerse the equipment/endoscope and all removable parts in a container of high level disinfectant/sterilant (i.e., Cidex OPA).
   a) Exception: Non-immersable probes shall only be immersed up to the connector.
   b) The container must be of a size to accommodate the item without undue coiling or overflowing, and ventilation must be sufficient to remove chemical vapors.
   c) To prevent damage to the item, the equipment/endoscope should not be soaked with other sharp instruments that could potentially cause damage.
   d) Flush the disinfectant into all channels of the endoscope until it can be seen exiting the opposite end of each channel. All

channels must be filled with the chemical so no air pockets remain within the channels. Complete microbial destruction cannot occur unless all surfaces are in complete contact with the chemical.

e) Cover the soaking basin with a tight-fitting lid to minimize chemical vapor exposure.

f) Soak the equipment/endoscope in the high-level disinfectant (i.e., Cidex OPA) for the time/temperature required to achieve HLD. Use a timer to verify soaking time. Document device and time.
   i) Cidex OPA requires 12 minutes minimum at room temperature.

g) Purge all channels completely with air before removing the equipment/endoscope from the high-level disinfectant/sterilant. Purging the channels preserves the concentration and volume of the chemical and prevents exposure from dripping and spilling.

7. RINSE AFTER MANUAL HIGH-LEVEL DISINFECTION:
   a. Thoroughly rinse all surfaces and removable parts of the equipment/endoscope, and flush all channels of the equipment/endoscope and its removable parts, with clean water per manufacturer's IFU (i.e., 2 gallons per rinse).
   b. Repeat rinsing with fresh rinse water for a total of 3 times.
      i. Tap water is acceptable for non-endoscopic devices.
      ii. Use sterile water or filtered potable water for endoscopic devices.
      iii. Rinsing prevents exposure and potential injury of skin and mucous membranes from chemical residue.
      iv. Fresh water should be used for each item and each rinse.
      v. The device should be totally immersed for a minimum of 1 minute with each rinse.
      vi. Discard rinse water after each rinse. Do not reuse water for any other purpose.
8. DRYING:
   a. All channels and the surface of the equipment/endoscope must be thoroughly dried before storage.
   b. In order to ensure equipment/endoscopes are thoroughly dried, they must be flushed with 70-90% ethyl or isopropyl alcohol prior to being dried with pressurized, filtered air either by the AER or manually, according to manufacturer's IFU.
      i. Alcohol shall be stored in a closed container between uses.
   c. Dry the exterior of the item with a soft, clean lint-free cloth.
   d. Dry all channels per manufacturer's IFU. If forced instrument air is recommended in the manufacturer's IFU, follow manufacturer's recommendations to determine air pressure limits for the particular model of endoscope.
      i. If forced instrument air is not recommended by the manufacturer's IFU, hang scopes vertically to drip dry for a minimum determined time prior to placing endoscopes in storage.
   a. Thoroughly rinse and dry all removable parts. Do not attach removable parts (e.g., valves) to the equipment/endoscope during storage.
9. STORAGE:
   a. Store equipment/endoscopes in a clean, well-ventilated, and dust-free area, according to endoscope and storage cabinet manufacturer's IFU.
      i. Transport and store items that are processed by HLD and stored before use in accordance with the device manufacturer's IFU and in a manner that protects the device from damage or contamination.
      ii. Cabinets and equipment/endoscopes shall be visually inspected to ensure cleanliness before storing.
      iii. Use storage cabinets that are made of a material that can be disinfected.

iv. Storage cabinets must be of sufficient height, width, and depth to allow flexible endoscopes to hang vertically without coiling and without touching the bottom of the cabinet.

v. Wipe down storage cabinets with a hospital-approved disinfectant at least every seven (7) days.

1) Endoscopes must be removed from the cabinet during storage cabinet cleaning.

b. Hang endoscopes in a vertical position, with all caps, valves, and other detachable components removed to prevent moisture accumulation and microbial growth.

c. Endoscopes should hang freely so they are not damaged or contaminated by physical impact or contact with one another.

d. Reusable buttons and valves shall be reprocessed and stored together with the endoscope as a unique set for tracking purposes.

e. Endoscopes may be stored for up to seven (7) days if they have been effectively reprocessed according to manufacturer's IFU and are stored in a way that keeps them completely dry and free from environmental and human contamination.

i. On the 7th day of storage, endoscopes must be reprocessed.

ii. Endoscopes shall have a tag indicating date reprocessing is due.

f. Staff should wear clean gloves when handling processed endoscopes.

8. Disposal of Cidex OPA:

a. Add a neutralizing agent to Cidex OPA in accordance with the manufacturer's IFU prior to disposal.

B. **REFERENCE(S):**

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.
2. Cidex OPA manufacturer's instructions for use.
3. Society of Gastroenterology Nurses and Associates, Inc. (2018). *Standards of Infection Prevention in Reprocessing Flexible Gastrointestinal Endoscopes*. Chicago.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 04/89

SUBJECT: HIV Testing: in an Occupational Exposure

REVISION DATE: 03/97~~;~~, 03/00~~;~~, 5/03~~;~~, 11/06~~;~~, 9/10, 06/15, 12/20

Patient Care Services Content Expert Approval:	~~05/20~~08/23
Clinical Policies & Procedures Committee Approval:	~~07/20~~09/23
Nursinge Leadership~~Executive Committee~~ Approval:	~~08/20~~10/23
Infection Control Committee Approval:	~~08/20~~01/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/20~~02/24
Administration Approval:	~~12/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/20

A. **PURPOSE:**

1. To provide a mechanism for human immunodeficiency virus (HIV) testing in the event of an occupational exposure.

B. **DEFINITIONS:**

1. Disclosure - includes all releases, transmissions, disseminations or communications whether they are made orally, in writing or by electronic transmission [Health & Safety Code Sections 120980(k)].
2. Exposed individual - any individual health care provider, first responder, or any other person (including any employee, volunteer, or contracted agent of any provider) who is exposed, within the scope of his or her employment, to the blood or other potentially infectious materials of a source patient.
3. First responder - police, firefighters, rescue personnel, and any other person who provides emergency response, first aid care, or other medically related assistance, either in the course of the person's occupational duties or as a volunteer.
4. Health care provider - include the following persons and entities:
   a. Licensed and certified health personnel, including physicians, nurses and other health personnel who work in hospitals, clinics, health dispensaries and facilities. Employees, volunteers or contracted agents of Knox-Keene Health Care Service plans. Professional students of any of the above.
5. HIV test - any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV [Health & Safety Code Section 120775].
6. Informed Consent - nature of the procedure; the risk, complications and expected benefits or effects of the procedure; any alternatives to the treatment their risks and benefits.
7. Significant exposure - direct contact with the blood or other potentially infectious materials in a manner that according to the California Division Occupational Health & Safey (CAL-OSHA) guidelines is capable of transmitting HIV.
8. Attending physician of the source patient - any physician who provides health care services to the source patient and includes any of the following:
   a. The private physician of the source patient.
   b. The physician primarily responsible for the patient who is undergoing inpatient treatment in a hospital.
9. Attending physician's designee - a registered nurse or Allied Health Professional (AHP) that has

been designated by the attending physician of the source patient.

10. Available blood or patient sample - blood or other tissue or material that was legally obtained in the course of providing health care services and is in the possession of the physician or other health care provider of the source patient prior to the exposure incident.
11. Certifying physician - any physician consulted by the exposed individual for the exposure incident. A certifying physician must have demonstrated competency and understanding of the applicable guidelines or standards of the CAL-OSHA. The law does not specify how this competency may be demonstrated.

C. **POLICY:**

1. California law [Health and Safety Code Sections 120260-120263] provides a narrow exposure notification and information mechanism to permit health care personnel and other first responders who have experienced a significant exposure to a patient's blood or other potentially infectious materials, to learn of the patient's HIV status. The exposed individual may have a source patient's blood, tissue or other material tested for HIV even though the patient refuses to be tested. The testing may be done provided the blood, tissue or other material was obtained prior to the exposure. [See Administrative Policy Notification to Pre-Hospital Personnel Exposure to Infectious Disease 530]
2. A person who has experienced an exposure to potentially infectious materials while rendering occupational or health care related services must request, in writing, evaluation by a physician within 72 hours of the exposure to determine if the exposure was significant.
3. The physician must evaluate and certify the significant exposure, including the nature and extent, in writing within 72 hours of the request. Exposed individuals, including physicians may not certify their own exposures as significant.
4. Regardless of the HIV status of the source person, the exposed individual will be given counseling regarding the transmission of HIV, the limitations of HIV testing, need for follow-up testing, and precautionary procedures to be followed. Tri-City Medical Center Employee Health Department will be responsible for the counseling of the exposed individual.
5. To establish baseline information, the exposed individual must be tested for HIV and the results of that test must be confirmed as negative before testing the source patient for HIV without the source patient's consent.
6. The certifying physician must provide certification that an exposure is significant to the source patient's attending physician. The certification must be in writing within 72 hours of certifying the exposure. The certifying physician must also request information on the HIV status of the source patient and the availability of blood or other patient sample.
7. The source patient's attending physician must respond to the certifying physician's request for the information within three working days.
8. If the source patient is known to be HIV positive, the attending physician must attempt to obtain the source patient's consent to release this information to the exposed individuals.
    a. If the source patient refuses or cannot be contacted, an attending physician of the source patient may advise the exposed individual of the source patients HIV status as soon as possible after certification.
    b. Consent for release of information is not required where the exposed individual is a treating health care provider.
    c. The hospital will attempt to obtain consent from a legal representative of an incompetent or deceased patient, however if the legal representative refuses or cannot be contacted or if there is no legal representative, this law may authorize the hospital to disclose the HIV status if known. Where authorization to disclose HIV status is unclear, hospital legal counsel should be consulted.
9. If the source patient's HIV status is not known, and blood or other patient samples are available, and if the exposed individual has tested negative on a baseline HIV test, the source patient is given the opportunity to consent to HIV test. Within 72 hours after receiving written certification of a significant exposure, the attending physician of the source patient must do all of the following:
    a. The attending physician must make a good faith effort to notify the source patient, or

the patient's authorized legal representative, of the significant exposure. This effort includes, but is not limited to, an effort to locate the patient by telephone or certified first class mail. The efforts to contact the source patient must be documented in the source patient's medical record.

b. If the source patient or legal representative is contacted, the attending physician must attempt to get the voluntary written informed consent to the HIV test.

c. The exposed individual is prohibited from directly seeking consent to HIV testing from the source patient.

d. If the source patient or the legal representative cannot be contacted after a good faith effort, it may be treated as if the source patient has refused to be tested.

10. If the source patient or authorized legal representative refuses consent for an HIV test, available blood may be tested and the exposed individual informed of the test results.
    a. An inability of the source patient to provide informed consent constitutes a refusal of consent provided all of the following conditions are met:
        i. The source patient has no legal representative authorized to consent on his behalf.
        ii. The source patient is incapable of giving consent.
        iii. In the opinion of the attending physician, it is likely that the source patient will be unable to grant informed consent within the 72-hour period during which the physician is required to act pursuant to Section 3.8 herein.
11. If the source patient is deceased, consent for HIV testing is deemed granted.
12. The exposed individual's employer will pay for the cost of HIV testing and counseling. Exposed individuals who are not employees of the health facility or health care providers are financially responsible for the cost of their own post-exposure evaluation, follow-up counseling and the cost of testing and counseling of the source patient. (Health & Safety Code Section 121135(f)).
13. The source patient or authorized legal representative must be given the option as to whether or not he or she is advised of the HIV results.
    a. If the source patient refuses to consent to HIV test and refused to learn of the results of the test, the patient must sign a form documenting the refusal.
    b. HIV test results may be placed in the source patient's medical record only if the patient has given written consent to be informed of the test results.
    c. If the source patient or legal representative refuses to be informed of the test results, the HIV test results may be provided to the exposed individual only in accordance with the then applicable CAL-OSHA regulations.
    d. The source patient's identity must be "encoded" in the HIV test result record.
14. If the exposed individual is informed of the source patient's HIV test results pursuant to the law, the exposed individual must be counseled regarding confidentiality laws protecting HIV test results, protecting the identity of the source patient and the penalties for violating the law.

D. **RELATED DOCUMENTS:**
1. Administrative Policy: Notification to Pre-Hospital Personnel; Exposure to Infectious Disease 530

E. **REFERENCE:**
1. Current California Hospital Association Consent Manual
2. California Code of Regulations, Title 8, Section 5193. Bloodborne Pathogens. https://www.dir.ca.gov/title8/5193.html **(reviewed 8/23)**
3. California Code, Health & Safety Codes: H&SC 120260-120263, 120775, 120980, & 121135 **(reviewed 8/23)**

Tri-City Medical Center	Patient Care Services	
PROCEDURE:	**LABELING MEDICATIONS/SOLUTIONS ON AND OFF A STERILE FIELD**	
Purpose:	To outline the process for the administration, handling, labeling and documentation of medications dispensed to the sterile field.	
Supportive Data	Patient Care Services Policy, Multi-Dose Vials, IV.HH Patient Care Services Policy, Identification, Patient, IV.A	
Equipment:	1. Alcohol swab 2. Vial or IV bag decanter 3. Diluent 4. Labels	5. Marking pen 6. Medication 7. Medicine cup or basin 8. Syringe and needle

A. **PROCEDURE:**

1. Verify physician/Allied Health Professional (AHP) order or preference card prior to obtaining medications for a surgery/procedure.
2. Confirm patient allergies prior to obtaining medications for a surgery/procedure or dispensing them to the sterile field.
3. Prepare medications using aseptic technique and according to manufacturer's instructions.
   a. Perform hand hygiene prior to medication handling/preparation.
   b. In the Operating Room (OR)/procedure room, prepare medications in a designated area that is free from clutter (i.e., mayo stand, prep stand) and disinfect the preparation area prior to use.
   c. Disinfect the rubber septum on all vials using alcohol and allow to dry prior to vial access.
   d. Multidose vials should be used for only one patient when prepared at the point of use (i.e., in the OR/procedure room) per Patient Care Services (PCS) Policy: Medication Administration.
4. Verify medication dosage calculations prior to administration.
   a. High risk medications (e.g., heparin) shall be double-checked by two licensed healthcare providers.
5. Medications and solutions shall be verbally and visually concurrently verified by the scrub and circulating nurse prior to dispensing to the sterile field. Verification shall include:
   a. Medication/solution name
   b. Strength
   c. Dose
   d. Expiration date
6. Deliver medications and solutions to the field in a sterile manner, by use of a transfer device (i.e., vial/IV bag decanter or needle and syringe).
   a. Do not pull out vial rubber stoppers and pour medications from vials. This practice results in contamination of the medication as it is poured from the vial.
7. Identify and label all medications and solutions on the sterile field.
   a. The scrub and circulator shall verbally and visually verify medications and solutions prior to dispensing to the sterile field, including medication/solution name, strength, dose and expiration date.
   b. Verify each medication individually and complete preparation steps, delivery to the sterile field, and labeling BEFORE another medication is prepared.
   c. Label all medication/solution containers (i.e., syringes, medicine cups, pitchers, aseptos and basins).
   d. Label all medications and solutions (e.g., water, saline, Lugol's solution, radiopaque dyes, antibiotic irrigation, betadine, chlorhexidine, acetic acid) when the

medication/solution has been removed from original packing or does not have the original manufacturer's label on the container.

e. Write the name of the medication, strength, amount (if not apparent from the container), and diluent (if applicable) on the label.

8. Verify the medication name, strength, and dose verbally when passing a medication to the physician/AHP performing the procedure.
9. Discard any solution or medication that is found unlabeled.
10. Verify all medications and solutions (including appropriate labels) on and off the field when there is a change of personnel during a surgery/procedure.
    a. Medications and solutions shall be verified by both the on-coming and off-going personnel.
    b. Hand-off report shall also include names and total amounts of medications already administered during the procedure.
11. Containers of all dispensed medications (i.e., ampules, vials and IV bags) shall be saved until the end of the procedure.
12. All medications dispensed to the sterile field shall be documented by the circulating nurse in the electronic health record (EHR).
    a. Surgery documents medications in the SurgiNet Operative Record.
    b. Medications dispensed to the sterile field but not used are documented as "not used".
13. All labeled containers on the sterile field and their contents shall be appropriately discarded at the conclusion of the procedure.

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

1. **Patient Care Services** ~~PCS~~ Policy: Medication Administration
~~1.~~ 2. **Patient Care Services Policy: High Risk/High Alert/Look Alike Sound Alike**

C. **REFERENCE(S):**

1. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**03/90**	**SUBJECT:**	**Missing Patient**
REVISION DATE:	**9/91; 12/96; 6/99; 5/03; 4/06 6/09; 6/11, 04/15**	**POLICY NUMBER:**	**8610-305**

Patient Care Services Content Expert Approval:	**~~04/20~~07/23**
Clinical Policies & Procedures Committee Approval:	**~~05/20~~02/24**
Nursing Leadership Approval:	**~~06/20~~03/24**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~07/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
   1. To define the process and responsibilities regarding missing patients.

B. **POLICY:**
   1. In the event that a patient cannot be located, an immediate search will be conducted by Clinical and Security personnel
   2. To initiate a search, the Charge Nurse/designee will contact:
      a. Nursing Leader/Administrative Supervisor
      b. Security - Inform Security of all patient identifying information including:
         i. Whether the patient is on a 5150 hold or 72 hour hold
         ii. Whether the patient is on conservatorship of any kind, is confused, and/or at risk for harm
      c. The Leader of the Unit/Service, Chief Nurse Executive and, if after hours or on weekends, the Administrator **On Call**.
   3. Nursing will coordinate an immediate search of patient's unit.
      a. This search will include: the surrounding stairwells, (entire flight up, and entire flight down), surrounding bathrooms/showers, treatment rooms, waiting rooms, supply rooms and elevator areas.
   4. Security will, simultaneously, conduct a search of the hospital grounds utilizing the Security: Missing Patient Search Checklist.
      a. Areas included are: All waiting rooms, lobbies, gift shops, ~~designated smoking areas,~~ cafeteria, all restrooms within immediate area of patient's unit (other than on patient floor) and exterior grounds
   5. The Security Department will contact other designated employees including **but not limited to**: Facilities Services~~, Lift Team~~ and Public Branch Exchange (PBX) as necessary.
   6. Open communication between Security and Nursing Leader or designee will be maintained throughout the entire search.
   7. If the patient is located, notify PBX immediately. PBX will contact Security via radio and the Nursing Leader or designee by phone.
      a. Search will be continued by all personnel until such time they are requested to discontinue
      b. Patients shall be returned to the unit if they are on a hold, under conservatorship, are confused, or a clear risk to themselves or others. (If unsure whether a patient may leave AMA or is at risk, detain the patient until a determination is made with the assistance of

Nursing, Social Services, ~~or~~ a Hospital Administrator **On Call**)

8. If the patient is not located within a reasonable amount of time~~,~~:

a. Nursing Leader

~~8.~~**i.** ~~wi~~**W**ll contact the ~~Clinical~~ Risk Manage**ment**~~r~~

~~a.~~**ii.** ~~The Nursing Leader w~~**W**ill delegate the task of contacting listed relatives for information regarding possible whereabouts of patient

~~b.~~**iii.** ~~The Nursing Leader w~~**W**ill ensure MD notification (and psychiatrist if one is involved).

~~c.~~**b.** The Security Department will be responsible to notify the appropriate law enforcement agencies as indicated. Examples of high-risk patients include: frail, elderly, those on a mental health hold, and confused patients.

c. Social Services will be contacted as indicated.

9. If the patient is not located, the Nurse Leader/designee will:

a. Complete appropriate note in the electronic health record (EHR)

~~d.~~**b. Ensure patient is discharged in the EHR.**

C. **FORMS/RELATED DOCUMENTS**:

1. Missing Patient Search Checklist - Security

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

RETIRE – no longer required with suspension of Women and Newborn Services

ISSUE DATE: 07/11

SUBJECT: Obstetrical and Postpartum Patients in the ED

REVISION DATE: 03/12, 04/16

Patient Care Services Content Expert Approval:	~~03/22~~11/23
Clinical Policies & Procedures Committee Approval:	~~04/22~~12/23
Nursing Leadership Approval:	~~05/22~~01/24
Department of OB/GYN Approval:	~~08/22~~ n/a
Department of Emergency Medicine Approval:	~~10/22~~01/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/22~~02/24
Administration Approval:	~~12/22~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

~~A. **PURPOSE:**~~

~~1. To provide guidelines for determining appropriate disposition and treatment of obstetrical (OB) patients at different gestational ages (GA) who present to Labor and Delivery (LD) or the Emergency Department (ED).~~

~~B. **POLICY:**~~

~~1. OB patients with obstetrical complaints/concerns and GA greater than or equal to 20 weeks 0/7days will be evaluated in LD.~~

~~2. Pregnant patients with non-obstetrical complaints/concerns of any GA shall be evaluated and treated in the ED.~~

~~a. These situations may include, but are not limited to:~~

~~i. Major trauma victims~~

~~ii. Patients involved in a motor vehicle accident~~

~~iii. Patients with unstable airway, difficulty breathing, or painful breathing~~

~~iv. Patients with cardiac complaints~~

~~v. Patients needing surgical procedures~~

~~vi. Patients with orthopedic complications or ocular emergencies~~

~~vii. Patients with infectious diseases (varicella, parvovirus, influenza, COVID-19, etc.) or suspicious rash which may be contagious to other pregnant patients~~

~~viii. Patients complaining of flu-like symptoms (fever, cough, body aches etc.)~~

~~b. Patients with a GA greater than or equal to 20 weeks 0/7days, the ED physician will consult the OB physician to determine fetal monitoring needs:~~

~~i. An LD RN performing external fetal monitoring evaluation in the ED.~~

~~ii. The ED RN may evaluate/confirm the fetal heart rate with a hand held doppler device.~~

~~iii. An ultrasound performed by the ultrasound technician.~~

~~3. Patients less than 20 weeks 0/7days GA will be seen in the ED. An OB consult will be obtained by the ED physician, if indicated.~~

~~a. A patient less than 20 weeks 0/7days GA may be evaluated in LD at the joint discretion of the attending OB provider and the LD Charge RN. Such conditions may include, but are not limited to:~~

~~i. Pyelonephritis~~

~~ii. Diabetes~~

iii. Incompetent Cervix
iv. Inevitable/active miscarriage

b. Admission of these patients will be considered on a case by case basis by the LD Charge RN.

4. An ED RN will gather the following information from the patient when presenting to the ED prior to calling the LD Charge RN.
   a. Patient Name
   b. Gestational Age/Estimated Due Date
   c. Gravida and Para (G/P)
      i. Gravida: number of pregnancies
      ii. Para: number of live births
   d. OB provider or Clinic name
   e. Chief complaint for presenting to the hospital
   f. Vital Signs (VS): Blood Pressure (BP), Heart Rate (HR), Respiratory Rate (RR), Oxygen level (SpO_2), Temperature (T), Fetal Heart Tones, numeric pain level.
      i. Notify LD Charge RN for any of the following VS:
         1) Systolic BP greater than or equal to 140mmHg or Diastolic BP greater than or equal to 90mmHg, repeat in 15 minutes.
         2) HR less than 40 beats per minute or greater than 110 beats per minute
         3) RR less than 12 breaths per minute or greater than 25 breaths per minute
         4) SpO_2 less than 95% on room air
         5) T greater than 38°C/100.4°F
         6) Fetal Heart Tones less than 110 beats per minute or greater than 160 beats per minute.

5. Patients who present to the ED and delivery is determined to be imminent or "in the process of delivering", shall be delivered in the ED (vaginal deliveries only).
   a. A "Code Delivery" will be initiated by the ED staff.
      i. The code will include the location of the delivery
      ii. The Laborist will respond to all Code Deliveries
      iii. The LD Charge RN or designee will notify the primary OB provider of the delivery and location as appropriate.
      iv. Refer to the Standardized Procedure: Precipitous Vaginal Delivery.

6. When a patient has delivered her newborn outside of the hospital the ED staff will:
   a. Notify LD and NICU Charge RNs of expected time of arrival
   b. Assess mother and newborn immediately upon arrival to determine stability for transfer to the LD and/or NICU unit
      i. If the mother or newborn are not stable they will remain in the ED and the appropriate code will be called for additional assistance.
   c. Banding the mother and newborn will be done per PCS Procedure: Newborn Identification Banding and Electronic Alarm Device.

7. All females of child bearing age presenting to the ED will be assessed for recent birth history.
   a. If the patient has given birth in the last 8 weeks, has abnormal vital signs as outlined below and is complaining of any of the following symptoms, she will be evaluated by the ED physician immediately and an OB physician will be consulted.
      i. Vital Signs (VS): Blood Pressure (BP), Heart Rate (HR), Respiratory Rate (RR), Oxygen level (SpO_2), Temperature (T), numeric pain level.
         1) Systolic BP greater than or equal to 140mmHg or Diastolic BP greater than or equal to 90mmHg, repeat in 15 minutes.
         2) HR less than 40 beats per minute or greater than 110 beats per minute
         3) RR less than 12 breaths per minute or greater than 25 breaths per minute
         4) SpO_2 less than 95% on room air
         5) T greater than 38°C/100.4°F

ii. Reported symptoms include:
1) Persistent headache, visual changes (floaters, spots), history of preeclampsia, shortness of breath, history of high blood pressure, chest pain, heavy bleeding, weakness, severe abdominal pain, confusion, seizures, fever or chills and swelling in hands or face.

b. If the patient is to be admitted for care, consult with the LD Charge RN or Mother Baby Charge RN for admission to unit.

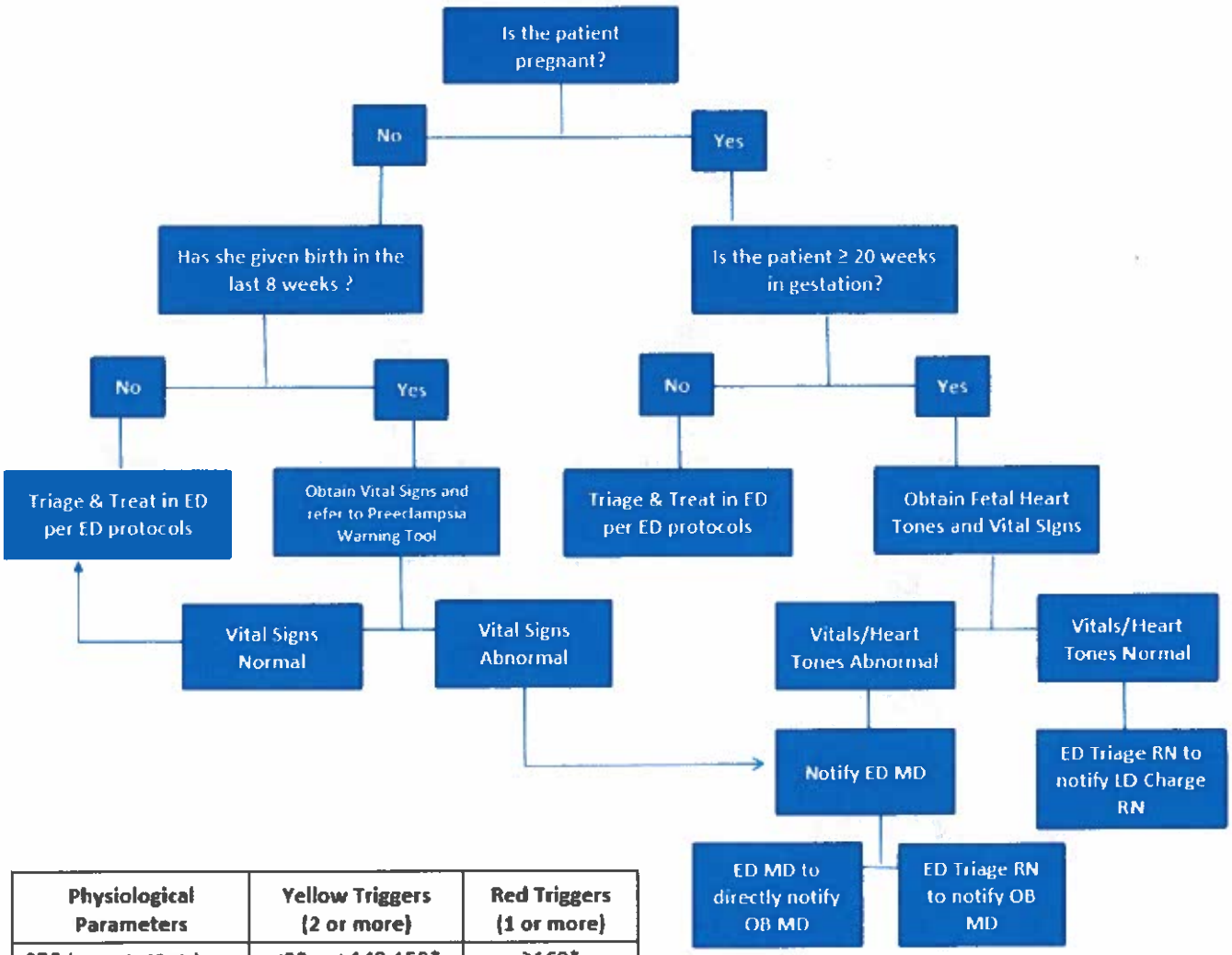
C. **RELATED DOCUMENT(S):**

1. PCS Procedure: Identification of Newborns
2. PCS Standardized Procedure: Precipitous Vaginal Delivery

D. **REFERENCE(S):**

1. American College of Obstetricians and Gynecologists. (2020). Committee opinion no. 667: Hospital-Based Triage of Obstetric Patients
2. American College of Obstetricians and Gynecologists. (2017). Obstetric Care Consensus no. 6: Periviable Birth
3. Emergency Nurses Association and Association of Women's Health, Obstetric and Neonatal Nurses. (2020). Consensus Statement: Emergency Care for Patients During Pregnancy and the Postpartum Period
4. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. (2017) Guidelines for Perinatal Care. 8th Edition

~~Attachment 1: OB Triage Algorithm in the ED~~



Physiological Parameters	Yellow Triggers (2 or more)	Red Triggers (1 or more)
SBP (repeat in 15min)	<90 or >140-159*	≥160*
DBP (repeat in 15min)	>90*	≥110*
MAP	<65 or >110	<55
HR	<40 or 110-120	>120
RR	<12 or 25-30	>30
O2 Sat on RA	<95%	<93%
Oliguria: ml/hr for ≥2 hrs	35-49	<35
Severe Red Triggers		
Altered mental status	Maternal agitation, confusion or unresponsiveness	
Neurologic	Unrelenting, severe headache unresponsive to medication	
Visual Disturbances	Blurred or impaired vision	
Physical	Shortness of breath or epigastric pain	
*If Yellow or Red BP triggers, recheck BP within 15 minutes		

IF O2 Sat <93% or RR >24 CONSIDER PULMONARY EDEMA

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PNEUMATIC TOURNIQUET USE AND SAFETY**
Purpose:	To outline nursing responsibilities for the safe use of pneumatic tourniquets.
Supportive Data:	Pneumatic tourniquets are frequently used for procedures involving the extremities. A tourniquet is a fabric-covered cylindrical bladder inflated by compressed gas or ambient air. It applies circumferential pressure on arterial and venous circulation, resulting in a relatively bloodless surgical field to promote visualization of structures during the procedure. Limb exsanguination is achieved by elevating and/or wrapping the limb, distally to proximally, with an ACE or esmarch rubber bandage before tourniquet inflation. Pain from the tourniquet is one of the most common complications related to pneumatic tourniquet use. Other possible complications include cardiovascular, respiratory, cerebral circulatory, and hematological effects related to the metabolic changes that result from ischemia caused by pneumatic tourniquet use, as well as temperature changes, postoperative swelling of the affected limb, and arterial injury.
Equipment:	Pneumatic tourniquet machine Tourniquet cuff (appropriately sized for patient) Padding

A. **POLICY:**

1. Pneumatic tourniquets and accessories should be inspected, tested and maintained by Biomed at the recommended time intervals according to manufacturer's recommendations.
2. The physician/Allied Health Professional (AHP) performing the procedure/caring for the patient determines if a tourniquet will be used for the procedure, after considering the risks and benefits to the patient, position and placement on the extremity.
3. The Registered Nurse (RN) shall assess the patient preoperatively for risks and potential contraindications related to the use of a pneumatic tourniquet, including, but not limited to: nerve injury, skin injury (e.g., blistering, bruising, or necrosis), impaired circulation or peripheral vascular compromise, previous revascularization of the extremity, extremities with a dialysis graft, compartment syndrome, deep vein thrombosis (DVT), extremity infection, tumor distal to the tourniquet and pain.
4. Prior to tourniquet cuff placement, the RN shall assess the patient's skin integrity at the intended tourniquet site, as well as size and shape of the extremity and peripheral pulses distal to the cuff.
   a. The width of the tourniquet and size should be individualized to the size and shape of the patient's limb.
5. Procedures involving pneumatic tourniquet control on two extremities should have the tourniquet tubing labeled to clearly identify which tubing belongs to which cuff and which is associated with each component of the tourniquet system.
6. Tourniquet cuff should be applied to the verified operative extremity in a location with adequate muscle mass to preserve nerves and vessels.
7. Tourniquet inflation pressure is determined by the physician/AHP and shall be established based on the systolic blood pressure, age of the patient and circumference of the extremity.
   a. Inflation should be kept to the minimum effective pressure.
8. Tourniquet time will be kept to a minimum and deflation managed to minimize risks to the patient.
9. Pneumatic tourniquets should be inflated and deflated under the direction of the surgeon/AHP and the anesthesiologist.
10. The surgeon shall be kept informed of the duration of tourniquet time. When prolonged tourniquet time is needed, it is recommended that the tourniquet be released for reperfusion of

the limb after two (2) hours of tourniquet inflation time, allowing blood to circulate for 15 minutes. The tourniquet may then be reinflated.

11. Pneumatic tourniquet activation indicators and pressure displays should be visible and audible alarms should be sufficiently loud to be heard above other sounds in the OR/procedure room.
12. After deflation, the tourniquet and padding should be removed from the extremity to allow full circulation to return to the extremity.
13. The patient should be monitored for pain and temperature while the tourniquet is inflated.
14. The patient should be monitored postoperatively for the following:
    a. Vital signs, including oxygen saturation and temperature
    b. Skin condition under the tourniquet (i.e., temperature, color, integrity)
    c. Pulses distal to the tourniquet cuff
    d. Surgical wound site (i.e., dressings, drains)
    e. Blood loss

B. **PROCEDURE:**

1. Prior to tourniquet use, the RN shall ensure the entire tourniquet system is complete, clean, and functioning according to the manufacturer's instructions for use (IFU).
    a. If a pneumatic tourniquet is not working properly or is damaged, it should be removed from service immediately and reported to Biomed for maintenance.
2. Turn on the pneumatic tourniquet machine and allow the machine to perform automatic system checks, according to the manufacturer's IFU.
3. Select the proper size tourniquet cuff. Tourniquet cuffs should overlap a minimum of three (3) inches and a maximum of six (6) inches.
    a. A tourniquet cuff that is too short can loosen after inflation.
    b. A tourniquet cuff with excess overlap can pinch skin folds.
4. Verify the correct surgical site prior to tourniquet cuff application.
5. Apply padding (i.e., low-lint soft padding, such as a limb protection sleeve, or two layers of stockinette) around the limb at the intended tourniquet cuff site, according to manufacturer's IFU.
    a. Padding should be smooth and wrinkle-free.
6. Apply the tourniquet cuff over the padding, according to manufacturer's IFU, ensuring the cuff tubing is positioned on or near the lateral aspect of the extremity.
    a. Lateral placement of the cuff tubing may help avoid pressure on nerves of the extremity and prevent kinking of the tubing.
7. Keep the patient's skin dry under the tourniquet cuff. Avoid pooling of prep solutions or irrigation under the cuff.
8. Avoid rotating the cuff after application. If the cuff must be repositioned, it shall be removed and reapplied in the desired location.
9. Connect tubing from the pneumatic tourniquet machine to the cuff, according to manufacturer's IFU.
10. Program pressure settings as ordered by the physician/AHP. Program and operate the tourniquet according to manufacturer's IFU.
11. Completely remove the deflated cuff and any underlying padding immediately following final cuff deflation.
12. Examine extremity after the tourniquet is removed for color, warmth, and the presence of a palpable pulse.

C. **DOCUMENTATION:**

1. Document tourniquet information in the Electronic Health Record (EHR), including the following information:
    a. Tourniquet equipment ID number (i.e., serial number)
    b. Cuff pressure
    c. Time inflated and deflated

d. Location of tourniquet cuff
e. Skin condition under the cuff before tourniquet cuff application and after tourniquet cuff removal
f. Name of person applying the tourniquet cuff
g. Name of person removing the tourniquet cuff

2. Surgery RN's document tourniquet use in the Operating Room (OR) Record.

D. **REFERENCE(S):**

1. Rothrock, J. C. (2015). Alexander's Care of the Patient in Surgery (15th edition). St. Louis, MO: Elsevier.
2. Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 10/05	**SUBJECT: Single Use Devices, Reprocessing of**
REVISION DATE: 06/09	**~~POLICY NUMBER: IV.KK~~**
Patient Care Services Content Expert Approval:	**09/23**
Clinical Policies & Procedures Committee Approval:	**~~06/09~~12/23**
Nursing Leadership Approval:	**01/24**
Infection Control Committee Approval:	**01/24**
~~Patient Care Quality Committee Approval:~~	**~~7/09~~**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~7/09~~02/24**
Administration Approval:	**03/24**
Professional Affairs Committee Approval:	**~~08/09~~03/24**
Board of Directors Approval:	**08/09**

A. **PURPOSE**:

~~A.~~**1.** To define and identify responsibilities and policies for the reprocessing and reuse of single-use medical devices in order to provide and ensure safe and quality patient care.

~~A.~~B. **DEFINITIONS**:

1. **Medical Device Reprocessing:** The decontamination, cleaning, functional testing, inspection, packaging and sterilization of devices that have been labeled by the original manufacturer as single use.
2. **Cleaning:** The process of removing all visible foreign material from the devices.
3. **Contractor:** For purposes of this policy, the vendor that has contracted with this facility to perform the reprocessing function.
4. **Disinfection:** The cleaning and use of germicidal agents to eliminate pathogenic microorganisms on inanimate objects.
5. **Expired:** Devices that are unopened and have exceeded the shelf life recommended by the manufacturer.
6. **Invasive devices:** Devices used in invasive procedures, entering the vascular system or other internal body systems.
7. **Non-invasive devices:** Devices that are contaminated by contact with a patient, but the contact was a non-invasive procedure.
8. **Open/Unused:** Opened but unused devices are single-use, disposable devices whose sterility has been breached or compromised, or whose sterile packages were opened but the devices were not used on a patient; that is, they have not been in contact with blood or body fluids.
9. **Reprocessing:** Reprocessing includes all of the steps performed to make a contaminated reusable or single-use device patient-ready. The steps may include cleaning, functional testing, repackaging, relabeling and sterilization.
10. **Sterilization:** Sterilization is the application of a terminal process designed to remove or destroy all viable forms of microbial life, including bacterial spores, to an acceptable sterility level.
11. **Testing:** The process of visually inspecting and functionally testing devices to ensure they meet all product specifications.
12. **Used:** Devices that have been in contact with, or exposed to, a patient during patient care.

~~B.~~C. **POLICY**:

1. The Clinical Value Analysis Team has approved the reprocessing of select devices that are labeled single-use and/or disposable. The reprocessing service is contracted with a vendor ~~(ASCENT)~~ **(Medline or Stryker)** that is Food and Drug Administration (FDA) registered and

operates in accordance with FDA regulations, including Quality System Regulations **(QSR)** with design controls ~~(QSR)~~ and Good Manufacturing Practices (GMP), as well as the most current FDA regulations

2. These devices come under two classifications:~~,~~ Used and Open/Unused.
3. ~~The Clinical Value Analysis Team or its designees shall maintain a list of devices being reprocessed.~~
4. **3.** The reprocessing service shall include all of the following elements:
   a. Collection and shipping of devices to the reprocessor
   b. Decontamination and cleaning
   c. Inspection and functional testing
   d. Packaging
   e. Sterilization
   f. Return to facility

~~C.~~**D. PROCEDURE:**

1. Policies related to Standard Precautions must be followed in the handling and preparation of used single-use medical devices for shipment to the contractor.
2. According to the contractor's protocols, each device shall have a tracking number applied **to record how many times the device has been reprocessed**~~, with the exception of open/unused devices~~.
3. Each device shall undergo the protocols designed and implemented by the contractor for the following with the exception of open/unused devices:
   a. Decontamination and cleaning of devices sent from client facilities for reprocessing.
   b. Functional testing process of the reprocessing service.
4. Each device shall have a label attached to the packaging that will identify the contractor as the reprocessing company.
   a. In addition, the label shall indicate the Original Equipment Manufacturer (OEM) and device description.
5. All reprocessed devices shall be packaged and labeled in accordance with the contractor's protocols.
   a. The contractor's packaging shall try to be consistent with the original manufacturer's packaging.
6. The devices shall be returned to the facility after having undergone and passed the **sterilization,** inspection and testing protocols.
   a. A device shall come to the end of service when it has undergone the number of reprocessing cycles in accordance with regulatory requirements **as tracked by the contractor**.
7. A device **will** ~~may~~ be rejected **and not returned to the facility** for having failed to pass the quality inspection and testing protocols.
8. A report shall be forwarded to Supply Chain Management that indicates which items are available for **purchase and** returned to the facility.
   a. ~~The report (Quote) shall also indicate which items have been rejected or are unable to be reprocessed.~~
9. If devices that are not on the Facility Device Identification List are sent to the contractor, the **contractor will properly dispose of the device.** ~~appropriate department shall be made aware of the device and a request sent to authorize the contractor to reprocess the device or discard it.~~
10. The contractor shall provide containers for the collection of devices to be reprocessed. These containers will comply with all regulations applicable for collecting and shipping devices for reprocessing.
    a. The collection containers shall be clearly identified as being for reprocessing and shall have the contractor name prominently displayed.
    b. The Clinical Value Analysis Team or its designees shall designate collection locations and provide storage and preparation areas for this function.

c. It is the contractor's responsibility to ensure adequate collecting and shipping are being performed in accordance with agreed-upon scheduling protocols and transportation vendors.
d. The contractor shall provide shipping boxes that comply with applicable regulations.
   i. The shipping system shall include transportation vendor approvals and preprinted shipping labels.
e. Terms agreed upon for this function are in the Service Agreement.

~~11. Upon approval of the Request for Service (Quote) and the return of the reprocessed devices to the facility, the devices shall be shipped via an authorized vendor to the designated shipping address or department.~~
~~a. Terms agreed upon for this function are in the Service Agreement.~~
~~12. Any problems or adverse outcomes related to a reprocessed device shall immediately be brought to the attention of the Clinical Value Analysis Team or its designees.~~
~~13.~~**11.** The Clinical Value Analysis Team or its designees shall be notified of any corrective actions, product complaints or preventive actions **via the electronic event reporting system~~RL Solutions~~**.
~~14.~~**12.** This policy is applicable to all areas encompassed within the practice of reprocessing single-use devices. Tri-City Medical Center does not reprocess single use or disposable devices **with the exception of the designated reprocessing contractor(s)**.

~~D.~~E. REPROCESSING CONTRACTOR REQUIREMENTS:

1. The reprocessing contractor shall be registered with the FDA.
2. The contractor shall meet applicable federal regulations and guidelines of the FDA, GMP, QSR with design controls, International Standards Organizations (ISO), Occupational Safety and Health Administration (OSHA) and Environmental Protection Agency (EPA). In addition, the contractor shall meet all applicable guidelines of AAMI, The Joint Commission, the California Department of Public Health, and the agency regulating medical waste.
3. The contractor shall clean, decontaminate, inspect, functionally test, package, sterilize, and return reprocessed devices to the facility in a timely manner so as not to affect the quality of patient care.
4. The contractor shall maintain a Quality Assurance Program of tracking devices used to determine the number of reprocessing cycles undergone by each device.
   a. Final approval for the number of cycles shall be established jointly by the contractor and health care facility within **FDA** regulatory requirements.

~~5. The contractor shall maintain an insurance/warranty policy to be no less than $25 million, and extend said policy to the hospital as "additionally insured."~~

~~6.~~**5.** The contractor shall provide an adequate supply of collection containers for the collection and shipping of devices to the reprocessing facility.
~~7.~~**6.** Collection containers shall be provided for **Open/Unused** and **Used** devices, and these containers will be clearly marked to indicate the contents are for reprocessing.

~~E.~~F. HOSPITAL REQUIREMENTS:

~~1. The facility, in conjunction with the contractor, shall determine those devices that may be reprocessed. Only approved devices will be accepted from the reprocessor. These items are:~~
~~a. *Compression Sleeves*~~

1. Each department shall work with the contractor representatives to ensure compliance with collection of devices for reprocessing and appropriate utilization of reprocessed devices that are returned to the facility or department.

~~F.~~G. CLINICAL VALUE ANALYSIS TEAM RESPONSIBILITIES:

1. The Clinical Value Analysis Team shall determine which devices will be reprocessed.
2. The committee shall be involved with future directions and reports on the progress and summary success of the reprocessing program.
3. It is the responsibility of the Clinical Value Analysis Team or designees to determine safe reuse practices and establish a policy for reprocessing.

a. The Clinical Value Analysis Team or its designees shall maintain policies and procedures.

4. Approval of any matters regarding the practice of reprocessing single use devices must come from this committee.
5. Records, reports, policies, procedures or successful implementation suggestions shall be under the direction of the Clinical Value Analysis Team and shall only be available for dissemination among hospital departments upon committee approval.

~~G.~~H. REFERENCES:

1. APIC Text, 2005, *Reprocessing of Single-Use Devices*
2. *www.fda.gov*
3. www.ascenths.com/ (Ascent Healthcare website)

~~General Products~~

~~DVT~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY

ISSUE DATE: 07/11

SUBJECT: Skin Antisepsis, Surgical/Procedural, Patient

REVISION DATE: 03/14, 09/17, 12/20

Patient Care Services Content Expert Approval:	~~05/20~~08/23
Clinical Policies & Procedures Approval:	~~06/20~~09/23
Nursing Leadership Approval:	~~07/20~~10/23
Operating Room Committee Approval:	~~08/20~~02/24
Infection Control Committee Approval:	~~09/20~~01/24
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/20~~02/24
Administration Approval:	~~12/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/20

A. **PURPOSE:**
   1. To provide guidelines for surgical/procedural site skin antisepsis.

B. **POLICY:**
   1. The surgical/procedural site and the surrounding area shall be free of dirt, debris, alcohol-based hair or skin products, lotions, deodorant, emollients, and cosmetics before surgical/procedural preparation.
      a. For surgery on the hand or foot, the nails on the operative extremity should be clean and natural, without artificial nail surfaces (i.e., acrylics, nail extensions).
   2. The surgical/procedural site shall be assessed before skin preparation.
      a. Presence of lesions, rashes, warts or other skin conditions at the surgical/procedural site shall be documented and the surgeon shall be notified.
      b. Jewelry or body piercings should be removed before skin preparation.
   3. Hair at the surgical/procedural site should be left in place whenever possible. If the presence of hair will interfere with the surgical procedure/procedure and removal is necessary, the following precautions shall be taken:
      a. Hair removal shall be performed as close to the time of surgery/procedure as possible.
      b. Hair removal at the surgical/procedural site shall be performed according to physician orders.
      c. Hair removal shall be done in a manner that preserves skin integrity.
         i. Clip hair at the surgical/procedural site in a manner that minimizes injury to the skin.
         ii. Whenever possible, remove hair in a location outside the operating room.
         iii. If removing hair outside the operating room is contraindicated or not feasible, remove hair in the operating room/procedure room in a manner that prevents dispersal of hair into the environment, such as by wet clipping or by closely gathering hair with a hair collection device (i.e., suction or adhesive device).
         iv. Electric or battery-powered clippers with a disposable or reusable head that can be disinfected between patients is preferred.
         v. Razor use is strongly discouraged, but if used wet shaving is preferable to dry shaving.

vi. A sterile razor may be used by the surgeon to remove hair from the scrotum for scrotal procedures and implant cases involving the scrotum. The surgeon shall be provided a sterile razor and supplies to complete a wet shave.

4. The surgical/procedural site and surrounding area shall be prepared with a Food & Drug Administration (FDA) approved antimicrobial agent in accordance with manufacturer's written instructions for use (IFU).
   a. Selection of antimicrobial agents shall be based on patient allergy or sensitivity, incision location, procedure type, skin condition, and physician preference.
   b. Skin antiseptics shall be packaged in single-use containers and shall be used in the full concentration as packaged by the manufacturer; do not dilute skin antiseptics prior to use.
   c. The surgical/procedural site shall be prepared by personnel who are knowledgeable about the patient and have demonstrated competency in skin preparation techniques.
      i. Preps shall be performed by a Registered Nurse (RN) or Physician/Allied Health Professional (AHP).
         1) Advanced Care Technicians (ACTs), ~~Nursing Assistants,~~ Anesthesia Technicians or Surgical Technicians may prep under the direct supervision of an RN or Physician/AHP.
   d. Confirm the surgical/procedural site before performing preoperative skin antisepsis.
      i. The surgical/procedure site mark should remain visible after prep application.
   e. Preoperative skin antiseptic agents shall be applied using sterile technique, proceeding from the incision site to the periphery, and according to manufacturer's IFU.
      i. Perform hand hygiene before applying preoperative skin antiseptic.
      ii. Wear sterile gloves and use sterile supplies when performing preoperative patient skin antisepsis.
      iii. Arms may be covered during performance of preoperative skin antisepsis.
      iv. Items that touch the patient's skin after preoperative skin antisepsis should be sterile to prevent introduction of microorganisms at the surgical/procedural site.
      v. Apply the skin antiseptic to an area large enough to accommodate potential shifting of the surgical/procedural drapes, extension of the incision, potential additional incisions, and potential drain sites.
      vi. Discard the prep applicator after contact with a peripheral or contaminated area.
      vii. Highly contaminated areas (e.g., anus, colostomy) near the surgical/procedural site should be isolated with a sterile barrier drape.
      viii. If a highly contaminated area is part of the procedure, the area with a lower bacterial count is prepped first, followed by the area of higher contamination.
      ix. An intestinal or urinary stoma within the surgical/procedural field should be cleansed gently and separately from the rest of the prepped area.
      x. When prepping the anus, vagina, or a stoma, sinus, ulcer, or open wound, the sponge should be applied once to the area and then discarded.
      xi. Vaginal preps for procedures that include the abdomen should be performed in a manner to prevent splashing of antiseptic agent expelled from the vagina onto the prepped abdomen.
         1) Vaginal preps, inclusive or exclusive of Foley catheter insertion, are started and finished by the same RN. The vaginal prep sponges are removed from the vagina prior to disposal of prep supplies/Foley catheter supplies, to prevent unintentional retention of the vaginal prep sponges.

5. Patient skin antisepsis shall be done in a manner that preserves skin integrity and prevents injury.
   a. Antimicrobial agents shall not be allowed to pool beneath the patient, tourniquets, electrocardiography (ECG) electrodes, positioning equipment, or electrosurgical dispersive pad. Remove any material near the patient that is in contact with the skin antiseptic solution and replace as necessary.

b. Place a fluid-resistant pad under the patient's buttocks during preoperative skin antisepsis for patients in the lithotomy position. Remove the pad after the antiseptic is dry and before sterile drapes are applied.
c. Apply the antiseptic with care (i.e., gentle friction) on fragile tissue, burns, open wounds, or malignant areas.

6. Skin antiseptics shall be stored in the original, single-use container, according to manufacturer's IFU.
7. Special considerations for flammable (i.e., alcohol-based) antiseptic solutions include:
   a. Prevent the flammable skin antiseptic solution from pooling or soaking into linens or the patient's hair by:
      i. Use sterile towels to absorb drips and excess solution during application.
      ii. Remove materials that are saturated with the skin antiseptic before the patient is draped.
      iii. Wick excess solution with a sterile towel to help dry the surgical/procedural prep area completely.
   b. Allow sufficient time for the flammable skin antiseptic solution to dry completely and vapors to dissipate before the surgical/procedural drapes are applied and any heat/ignition source is used.
      i. Heat/ignition sources include: electrosurgery, cautery, laser, burrs, drills, defibrillators, and light cords.
      ii. Verify in a "time out" before starting the procedure that a flammable skin antiseptic was used to prep and confirm dry time was met.
8. Skin preparation agents shall not be warmed prior to application.
9. Assess the patient's skin for injury after surgery.
10. Patient skin preparation, hair removal, and skin condition shall be documented in the Perioperative/Procedural record.

C. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Sterile Technique

D. **REFERENCE(S):**
1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Cent
Oceanside, California

PATIENT CARE SERVICES

RETIRE – the process for ordering specialty beds needs updating. Once new process identified, add as a related document to the Skin and Wound Policy

ISSUE DATE: 03/02

SUBJECT: Special Order Durable Medical Equipment and Specialty Beds

REVISION DATE: 02/04, 11/06, 07/09, 11/12, 02/13

~~**POLICY NUMBER: IV.S**~~

Department Approval:	~~11/17~~01/24
Clinical Policies & Procedures Committee Approval:	~~11/17~~01/24
Nursinge Leadership~~Executive Council~~ Approval:	~~12/17~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~02/24
Administration Approval:	
Professional Affairs Committee Approval:	02/18
Board of Directors Approval:	02/18

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

~~1. Durable Medical Equipment includes all special order orthotic devices and specialty beds includes all beds and mattresses from outside vendors.~~

~~B. **POLICY FOR INPATIENTS:**~~

~~1. Specialty Beds/Mattresses:~~

~~a. Do not require a physician's/Allied Health Professional's (AHP) order.~~

~~b. A order will be entered into Cerner for the specific item needed, i.e. bed mattresses.~~

~~i. Order information – details~~

~~ii. Special Instructions - Company preference if specified~~

~~c. Sterile Processing Department (SPD) will notify the ordering department of delivery time, including any anticipate delays~~

~~d. SPD Manager will review and approve electronic invoice.~~

~~e. The Biomedical Department will perform a safety check and will retain the safety check paperwork.~~

~~f. SPD shall obtain the receipt.~~

~~g. Notify SPD when bed/mattress is no longer required.~~

~~C. **DURABLE MEDICAL EQUIPMENT UPON DISCHARGE:**~~

~~D. Case Management to facilitate ordering of devices:~~

~~E. Neonatal patients:~~

~~F. An order must be received from the Neonatal Intensive Care Unit (NICU) physician, pediatrician or AHP.~~

~~G. A documented reason for prescribing the equipment shall be included in the order.~~

~~H. Medical needs will be documented.~~

~~I. The Certificate of Medical Necessity for Apnea Monitors form is completed for Medi-Cal patients.~~

~~J. The case manager/social worker will arrange for the equipment to be delivered to the hospital unit prior to the infant's discharge.~~

~~K. A representative from the DME agency will provide education on use of the equipment to the caregivers of the infant.~~

~~The pediatrician will follow the infant's progress.~~

~~Tri-City Medical Center~~
Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/10 **SUBJECT:** Surgical Attire

REVISION DATE: 02/12, 06/17, 06/20

Patient Care Services Content Expert Approval:	~~03/20~~06/23
Clinical Policies and Procedures Approval:	~~03/20~~07/23
Nursinge Leadership~~Executive Committee~~ Approval:	~~04/20~~08/23
Operating Room Committee Approval:	~~04/20~~02/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~02/24
Administration Approval:	~~06/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **PURPOSE:**
1. To provide guidelines for attire worn within the semi-restricted and restricted areas of the surgical environment and invasive procedure areas, for patient and personnel safety.

B. **DEFINITION(S):**
1. **Restricted areas:** Areas which are accessible only from semi-restricted areas. Wearing of surgical attire is required and masks are required in the presence of open sterile supplies or scrubbed personnel. Restricted areas include the Operating Rooms (OR's) and sub-sterile rooms.
2. **Semi-restricted areas:** Areas which are accessible from unrestricted, other semi-restricted, or restricted areas. Wearing of surgical attire is required. Semi-restricted areas include corridors leading to the Operating Rooms, sterile storage rooms, peripheral support areas, and sterile processing areas.
3. **Unrestricted areas:** Areas which are accessible from the exterior of the building, other unrestricted areas or semi-restricted areas. Wearing of surgical attire is not required.
4. **Health care-accredited laundry facility: An organization that processes health care linens and has successfully passed an inspection of its facility, policies and procedures, training programs and relationships with customers.**

C. **POLICY:**
1. Clean surgical attire shall be worn when entering the semi-restricted and restricted areas.
   a. After each daily use, scrub attire shall be laundered at a health care--accredited laundry facility.
   b. Laundered surgical attire shall be stored in a manner that prevents contamination.
   c. Scrub attire that has been penetrated by blood, body fluids, or other potentially infectious materials must be removed immediately or as soon as possible, and replaced with clean attire.
   d. Remove surgical attire before leaving Tri-City Medical Center (TCMC).
   e. Personal ~~clothing~~**apparel** worn under scrub attire (i.e., a t-shirt worn under the scrub top) must be completely covered by the surgical attire and shall be laundered daily.
      i. Personal ~~clothing~~**apparel** is home-laundered, however, personal ~~clothing~~**apparel** contaminated with blood, body fluids, or other potentially infectious materials must remain at TCMC for laundering at a health care accredited laundry facility.

f. Scrub attire shall be made from fabric that is tightly woven and low-linting.
g. Arms may be covered during performance of pre-operative patient skin antisepsis.
   i. Use care not to contaminate the prep with a loose-fitting long sleeve.
h. If worn, cover apparel (i.e., lab coats) should be clean.
i. Visitors entering the semi-restricted or restricted areas (e.g., law enforcement officers, parents, biomedical engineers) should don either clean surgical attire or a single-use jumpsuit (i.e., bunny suit) designed to completely cover personal apparel.

2. All personnel entering the surgical/invasive procedure area must wear an identification badge/tag per Administrative Policy: Identification of Employees and Non-TCHD Employees 436.
   a. Identification badges shall be cleaned with a low-level disinfectant daily, and when the badge becomes soiled with blood, body fluids, or other potentially infectious materials.
   b. Identification badges shall be worn pinned to scrubs; identification tags (stickers) shall be placed directly on scrubs. Lanyards should not be worn.
   c. Identification badges/tags shall be worn above waist level.
   d. Decorative pins shall not be worn on scrubs.
3. Cover the scalp and hair **with hospital provided surgical bouffant cap or skull cap** when entering the semi-restricted and restricted areas.
   a. Remove head coverings at the end of the shift or when they are contaminated.
   b. **Personal home laundered hair and scalp covers shall:**
      i. **Be laundered daily**
      ii. **Be completely covered with a hospital provided surgical bouffant cap.**
      iii. **Remain at TCMC to be laundered by a health care-accredited laundry facility if contaminated with blood, body fluid or other potentially infectious material.**
4. Cover a beard when entering the restricted areas and while preparing and packaging items in the clean assembly section of Sterile Processing Department (SPD).
5. Wear clean shoe covers when entering the semi-restricted or restricted areas.
   a. Wear protective footwear that provides protection from falling or rolling objects. Open toed shoes shall not be worn.
   b. Fluid-resistant shoe covers or boots must be worn when gross contamination can reasonably be anticipated.
   c. Shoe covers are single-use personal protective equipment (PPE) and shall be removed immediately after use. After removal, discard the shoe covers and perform hand hygiene. Shoe covers may not be worn outside of the surgical suite/invasive procedure area.
6. Don a clean mask before each procedure.
   a. All personnel entering the semi-restricted or restricted areas of the surgical suite/invasive procedure area shall wear a mask when scrubbed personnel or open sterile supplies are present.
   b. Select the mask that provides the best fit for the individual. The mask should completely cover the mouth, nose, and chin and fit snugly in a manner that prevents gaps at the sides of the mask.
      i. Masks with ear loops may not provide secure facial fit and are not intended for use as surgical masks.
   c. Replace the mask and discard it whenever it becomes wet or soiled.
   d. Remove the mask last when worn in combination with other PPE, including a gown, gloves, or eye protection.
   e. Do not wear used masks hanging around the neck.
   ~~e.~~**f.** Remove the mask **last** by touching only the ties without touching the front of the mask. Discard it in a waste receptacle and perform hand hygiene.
7. Jewelry (i.e., rings, watches, and bracelets) shall not be worn on the hands or wrists in patient care areas.

a. For additional guidelines on jewelry, accessories and piercings, refer to TCMC Administrative Policy Dress and Appearance Philosophy.

8. All perioperative team members should maintain healthy fingernail and hand skin condition.
   a. Fingernails should be maintained short and natural. Fingernail tips should be no longer than 2mm (0.08 inch).
   b. Nail lacquer or enhanced nail lacquer (gel polish) may not be worn while performing the scrub role.
   ~~b.~~**c.** Artificial fingernails or extenders may not be worn in surgical/invasive procedure areas.
   ~~c.~~**d.** For additional guidelines on nail polish, refer to TCMC Administrative Policy Dress and Appearance Philosophy.
9. Personal items should be cleaned prior to bringing them into the semi-restricted or restricted areas.
   a. Bags (i.e., backpacks, briefcases) that are not able to be cleaned should be contained in a plastic bag or be stored in the unrestricted area.
   b. Cell phones, tablets, laptops and other personal communication or hand-held electronic devices should be cleaned before they are brought into the OR/invasive procedure area. Perform hand hygiene after device cleaning.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: Dress and Appearance Philosophy 415
2. Administrative Policy: Identification of Employees and Non-TCHD Employees 436

E. **REFERENCES:**
1. ~~AORN, Inc. (2020).~~ **Surgical Attire,** Guidelines for Perioperative Practice. Denver, **CO., AORN Inc., 2023, 1089-1103.**
~~1.~~**2. Hand Hygiene, Guidelines for Perioperative Practice. Denver, CO., AORN Inc., 2023, 268-307.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 3/02 **SUBJECT: Utilization of Staff, Staffing Patterns**

REVISION DATE: 6/03; 8/05; 5/06; 8/08; 6/09; 7/12 11/16 **POLICY NUMBER: VIII.A**

Patient Care Services Content Expert Approval:	**~~02/20~~06/23**
Clinical Policies & Procedures Committee Approval:	**~~04/20~~02/24**
Nursing Leadership Approval:	**~~05/20~~03/24**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **POLICY:**

1. Staffing patterns shall follow mandatory state regulations. In addition, patient acuity shall be assessed to ensure appropriate staffing levels.
2. The Nursing Leadership has accountability for staffing and work schedules.
3. Nursing staff to assist ~~the Registered Nurse (RN)~~ in the provision of patient care may be utilized as follows:
   a. Administrative Supervisor (AS):
      i. Assumes responsibility for supervision of staff as a representative of Administration.
      ii. Assumes administrative authority for the level of patient care and standards of care.
      iii. Acts as liaison between all hospital staff, patients, families, physicians, directors, and administration for routine administrative decisions for their shift.
      iv. Manages internal and external supplemental staff~~. in the absence of the Director, Education, Clinical Informatics, and Staffing.~~
   b. Charge Nurse/~~designee~~signee~~:~~
      i. Works under the direction of -Nursing Leadership.
      ii. Oversees direct and indirect patient care assignments.
      iii. Ensures patient care assignments are in writing and based on the following:
         1) Patient - Level of care (intensity of care needs, treatments, and medications, as determined by the Patient Classification System).
         2) Environment: unit geography, location of assigned patients in relation to each other, and safety.
         3) Technology: hemodynamic equipment, respiratory support equipment, and frequency of required monitoring activities.
         4) Supervision: staff competence, skills/abilities, staff mix, and workload ability.
         5) ~~Competency of delegating RN to carry out clinical and managerial responsibilities.~~
         6) ~~Availability of delegating RN for appropriate supervision of assigned staff in relation to activity of unit and patient assignment of charge personnel.~~
         7) Regular staff members are responsible for overseeing students, per diem, registry staff, and orientees.

iv. Document patient assignments each shift and include the following:
1) Name of ~~Charge Nurse/designee.~~
2) Name of RN responsible to supervise and/or orient any RN or non-RN personnel performing patient care, students, registry or traveler staff, or private duty nurses.
3) Name of each caregiver by licensure category and specific assignments listed by individual patient.
4) Assigned break coverage for each licensed staff member to ensure minimum staffing ratios are maintained at all times.
a) Documentation of break coverage shall include specific time of break relief.
b) The same licensure or higher is required for break relief coverage.

v. ~~Cerner staff assignment information will be electronically maintained in the "Staffing Acuity" shared drive folder.~~

c. Registered Nurse (RN):
i. Works under the direct supervision of the **nNursinge lLeadership or designee.**~~Charge Nurse, Nursing Leadership/designee.~~
ii. Plans, supervises, and evaluates the care of all patients by using the nursing process.

d. Procedural Nurse:
i. RN whose primary responsibility is to assist with invasive procedures.
1) Additional duties may be assigned by the **Nursing Leadership** ~~Clinical Manager~~/designee based on the hospital needs.
ii. If census and activity is low throughout the day, staff may be flexed.

e. Licensed Vocational Nurse (LVN):
~~ii.~~ **i. Licensed personnel who work under the clinical direction of the RN, nNursinge lLeadership or designee to provide a basic level of general nursing care.**

~~e.~~ **f.** Unit Secretary (US):
i. A clerical worker who enters information into the computer system and assists with reception duties.
ii. The US works under the direction of the RN and is supervised by **thea** ~~charge nurse or clinical manager on duty.~~ **nNursinge lLeadership or designee.**

~~f.~~ **g.** Monitor Technician:
i. A trained personnel who has demonstrated competency in recognition of cardiac arrhythmias.
ii. Works under the direction of the RN and is supervised by **the** ~~an ANM or designee on duty.~~ **nNursinge lLeadership or designee.**

~~g.~~ **h.** CNA/**Advanced Care Technician (**ACT)~~/Nursing Assistant~~:
i. A trained personnel who has been taught to perform tasks involving direct care services for patients.
ii. Works under the direction of the RN and is supervised by **thea nNurse lLeadership or designee.** ~~a Charge Nurse or designee on duty.~~

~~h.~~ **i.** Technicians:
i. A trained personnel who demonstrates competency in caring for patients in designated area of specialty.
ii. Works under the direction of the RN and is supervised by ~~the~~ **Nursing Leadership**~~ANM~~ or designee on duty.

~~i.~~ **j.** Psychiatric Liaison:
i. A trained personnel (for example licensed MFT/LCSW) who is primarily responsible to complete patient assessments and provides crisis intervention, including admission/transfer to an appropriate level of care as necessary **in the Emergency Department**.

4. Volunteers, student nurses, patient-acquired private duty staff, externs, ~~and patient safety technicians~~ may be utilized per policies.
5. Shift-To-Shift Staffing (if applicable)
   a. Acuity Measurement - A Patient Classification assessment is conducted once per shift for patients in all nursing units.
      i. ~~Labor & Delivery, clinical p~~**Procedural areas and the** ~~&~~ Emergency Department are excluded and utilize census only numbers.
   b. The Charge Nurse /~~designee~~ **Nursing Leadership** ensures all Patient Classification are completed for their units by ~~1400~~ **designated timeframes (for example 1500** and ~~0200~~ **0300).**
   c. The Charge Nurse /designee ~~then~~ completes the staffing needed for the next shift based on the acuity of the patients, minimum staffing ratios and the expected patient volume.
      i. This information is communicated to ~~the Staffing Office~~ **to the nursing unit leadership and to the Administrative Supervisor.**~~.~~
   d. **The Administrative Supervisor or designee will communicate to outside agencies for staffing needs.**
   e. ~~Staffing Office Representatives shall place calls as requested by the Administrative Supervisor or designee~~.
   f. After all TCMC available resources have been effectively utilized, the Charge Nurse/designee shall evaluate staffing the units using the **staffing matrix.** ~~TCMC tool.~~
      i. Staffing needs or staffing reductions due to periods of decreased census and patient requirements shall be coordinated by the ~~Staffing Office, Managers, Directors,~~ **Nursing Leadership** and/or Administrative Supervisors. This includes ensuring rotations are fair and equitable and specialized unit needs are covered.

B. **RELATED DOCUMENTS:**
1. Patient Care Services (PCS) Policy: Allied Health Students in the Patient Care Areas
2. PCS Policy: Nursing Students in Patient Care Areas
3. PCS Policy: Volunteers, Patient Care Services Departments

Tri-City Medical Center
Oceanside, California

RETIRE – follow Online Skills Negative-Pressure Wound Therapy

PATIENT CARE SERVICES

ISSUE DATE: 6/06

SUBJECT: Wound V.A.C. (Vacuum Assisted Closure), Negative Pressure Therapy Policy

REVISION DATE: 12/08, 06/11; 11/14

Patient Care Services Content Expert:	~~03/20~~01/24
Clinical Policies & Procedures Committee Approval:	~~05/20~~01/24
Nursing Leadership Approval:	~~06/20~~02/24
Medical Staff Department or Division Apprval:	n/a
Pharmacy and Therapeutics:	n/a
Medical Executive Committee Approval:	~~06/20~~02/24
Administration Approval:	~~07/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

~~A. **PURPOSE:**~~

~~1. To define the appropriate procedure for initiation of Wound VAC therapy and Vacuum Assisted Closure (V.A.C.).~~

~~2. To define appropriate assessment, documentation, monitoring, and maintenance of Wound V.A.C. therapy V.A.C. Instillation Therapy Option, and V.A.C. Prevena incisional management system.~~

~~B. **DEFINITIONS:**~~

~~1. Dehisced: the separation of a surgical incision or rupture of a wound closure.~~

~~2. Diabetic Ulcer: a wound that has failed to heal as a result of elevated glucose levels that have caused altered nerve function in the lower extremities, commonly located on pressure points of the foot such as the plantar surface and the metatarsal heads.~~

~~3. Eschar: black or brown, necrotic, devitalized tissue.~~

~~4. Fistula: an abnormal passage from an internal organ to the body surface or between two internal organs.~~

~~5. Flap: a layer of skin or other tissue surgically separated from deeper structures for transplantation or to cover an area that has been injured.~~

~~6. Graft: a tissue taken from a site and inserted into a new site to repair a defect in structure.~~

~~7. Necrosis: localized tissue death that occurs in groups of cells in response to disease or injury.~~

~~8. Osteomyelitis: local or generalized infection of bone and bone marrow.~~

~~9. Partial Thickness: tissue damage to the epidermis and part of the dermis. Abrasions, skin tears, and blisters are examples of partial thickness wounds.~~

~~10. Full Thickness: Ulceration that extends through the dermis to involve the subcutaneous tissue and if Stage 4, the muscle and possibly down to the bone.~~

~~11. Pressure Injury : localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.~~

~~12. Suction: dynamic pressure control~~

~~13. Therapeutic Regulated Accurate Care (T.R.A.C.) Pad: monitors and maintains target pressure at wound site ensuring consistent therapy is delivered.~~

~~14. Tunneling: course or path of tissue damage occurring in any direction from the surface or edge of wound leading to dead space.~~

15. Undermining: area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.
16. Vacuum Assisted Closure (V.A.C.): negative pressure device used to promote wound healing and stimulate granulation tissue.
    a. V.A.C. Ulta with VeraFlo (instillation therapy system) is indicated for patients who would benefit from negative pressure wound therapy, drainage and controlled delivery of topical wound treatment solutions over the wound bed.
    b. V.A.C. Prevena - incisional V.A.C. therapy placed over an intact surgical incision, usually placed in surgery to help prevent dehiscence and infection. The V.A.C. Prevena incision management system is left in place x 7 days post-operative. It will alarm with 3 beeps and turn off after 193 therapy hours. The dressing will become non-compressed. If patient is discharged, unit goes home with patient. Canister holds 45 mL.
    c. V.A.C. Prevena Plus – disposable home unit, sometimes used until patient can get traditional home wound V.A.C. authorized or for short term vac therapy at home. Canister holds 250 mL and compatible connector with V.A.C. Ulta. Disposable unit
17. V.A.C. GranuFoam: hydrophobic, black foam. More effective at stimulating granulation tissue and should be used for a wound with drainage.
18. V.A.C. Vers Foam: hydrophilic, white foam, pre-moistened with sterile water. Used for extremely painful wounds, controlled growth of granulation tissue, and tunneling or undermining wounds. Minimum pressure setting is 125 mmHg.
19. V.A.C. GranuFoam Silver: Hydrophobic, black foam impregnated with silver, allows for continuous delivery of silver into wound protecting against many types of bacteria and fungus.
20. V.A.C. White Foam: hydrophobic foam used for instillation therapy

C. **POLICY:**

1. When a patient has a wound that is difficult to heal and does not respond to therapy, or a complicated dressing change, a referral may be made per physician order to the Wound Nurse for Wound Evaluation and Treatment. The SkinWound Team is available for questions at extension 3793 or cell phone number 760-851-9903. .
2. Indications for wound V.A.C.:
    a. Acute, chronic, or traumatic wounds
    b. Dehisced Wounds
    c. Diabetic Ulcers
    d. Pressure Injury
    e. Grafts
    f. Flaps
    g. Full Thickness Wounds
    h. Enteric Fistulas, in special circumstance
    i. Infected wounds
    j. Venous ulcers
3. Contraindications:
    a. Malignancy in wound – malignant cells should be removed prior to initiation of V.A.C. therapy.
    b. Untreated osteomyelitis – wound should be free of osteomyelitis or receiving concurrent antibiotic therapy.
    c. Non-enteric and unexplored fistula
    d. Necrotic tissue with eschar present – wound should be surgically debrided prior to initiation of V.A.C. therapy.
    e. Do not use V.A.C. Ulta with VeraFlo (instillation therapy) on wounds:
        i. At risk of bleeding
        ii. New flaps and grafts
        iii. Acute enteric fistulas
        iv. With unexplored tunnels or unexplored undermining as fluid may enter into unintended cavities

v. Requiring continuous therapy
vi. With unstable structures, such as unstable chest wall or non-intact fascia
vii. With high exudates
viii. Closed incisions
ix. Where hemostatic agents have been used in the wound bed
x. With Granufoam silver because solutions may negatively impact the benefits of the silver dressing

4. Precautions
   a. Active Bleeding
   b. Difficult wound hemostasis
   c. Anticoagulant therapy
   d. When wound V.A.C. therapy is initiated close to blood vessels or organs protective barriers will be used.
   e. Wounds with enteric/non-enteric fistulas require special precautions, initiate dressing per specific physician order or make a referral to Wound Nurse for Wound Evaluation and Treatment
   f. For V.A.C. Ulta with VeraFlo (instillation therapy):
      i. Some irrigants/solutions utilized with instillation therapy may adversely affect bioengineered materials. Refer to manufacturer guidelines
      ii. Use only solutions or suspensions indicated for topical wound treatment according to solution manufacturer guidelines.
      iii. Use solutions that are compatible with V.A.C. dressings and disposable components.
5. A physician order is required to initiate wound V.A.C., V.A.C. Instillation therapy and Prevena incision management system.
   a. The primary nurse is responsible for ensuring appropriate orders for the wound V.A.C. are documented in the electronic health record (EHR).
6. Orders should indicate:
   a. Type of wound V.A.C. therapy
   b. Area of placement
   c. Therapy setting (continuous or dynamic pressure control))
   d. Pressure setting for suction (125 mmHg normal preset)
   e. Frequency of dressing change and healthcare provider responsible for performing dressing change
   f. For V.A.C. Ulta with VeraFlo (instillation therapy) include:
      i. Medication and dosage for irrigation
      ii. Instillation infusion time
      iii. Instillation hold and pressure suction cycles
7. All supplies are latex free and obtained from the Sterile Processing Department (see Wound V.A.C. Supply List).
8. Ensure Nutritional Consult has been made on each patient to optimize V.A.C. therapy. If no order exists the nursing staff will make the proper referral.
9. Assessment
   a. Assessment of dressing is done each shift or as needed and documented in the EHR. Dressing should be monitored every 2 hours to ensure dressing is intact and wound V.A.C is maintaining suction.
   b. Assure proper functioning of wound V.A.C. machine. Check power cord, seal check light is on and battery is being charged.
   c. Photograph of wound will be taken upon initiation of wound V.A.C. (except during surgery) and at least weekly (during wound V.A.C. dressing change).

D. **PROCEDURE**:
1. Initiation:
   a. Wound V.A.C. shall be initiated per physician order

i. V.A.C. Ulta with VeraFlo (instillation therapy) will be initiated by Operating Room (OR), Post Anesthesia Care Unit (PACU), Wound/Ostomy registered nurses (RNs) or specially trained RN.
   1) Instillation (irrigation solutions) will be provided by Pharmacy.
   2) V.A.C. Ulta with VeraFlo (instillation therapy) set-up:
      a) Adjust hanger arm on left side of unit and hang solution bottle.
      b) Prime tubing by spiking solution bottle using adapter with Veralink cassette spike. Clamp off tubing and insert Veralink cassette into left side of machine.
      c) After V.A. C. Veraflo foams applied, secure VeraFlo pad (cut 2.4 cm opening). Connect dressing tubing to canister tubing and VeraFlo tubing to Veralink connection.
      d) Configure therapy settings. Select V.A.C. VeraFlo therapy.
      e) Ensure fill assist is on, set soak time, V.A.C. therapy time, and target pressure/intensity. When complete press OK.
      f) Confirm settings and choose OK after unclamping VeraFlo tubing.
      g) Press start/stop fill assist and observe the wound bed fill with solution. Press stop/start again when volume is sufficient.
      h) Select OK to confirm volume displayed and return to home screen.
      i) If the wound bed is overfilled with solution press "reset" to remove solution and return to fill assist to reset volume.
   3) V.A.C. Prevena incisional management system
      a) Initiation of the Prevena is recommended to be place in OR by the Surgeon or the Wound Team. The sterile dressing is opened and placed along the incisional line using sterile technique.
      b) Press firmly around the dressing edges to prevent a leak alert
      c) The canister is connected to the portable Prevena unit.
      d) The circulating RN will press and hold down on the start button for the count of 15 seconds. This will initiate the 192 hour (eight days) life cycle of the therapy unit.
      e) The unit will come on and immediately compress the foam pad and place dressing.
      f) When the dressing does not compress, therapy is not at the proper pressure.
      g) Assess for leaks: Use Prevena patch strips for pad and place dressings.
      h) Often times, the air leak could be coming from around a JP drain that is adjacent to the incision.
      i) Close the air leak by placing a patch strip over the edges of the pad and place dressing.
      j) If the canister becomes full quickly after surgery. The RN can call SPD to request a Hospital V.A.C. Ulta unit with a canister.
      k) The dressing should not be removed; rather the RN should stop up the hospital unit and attach the canister. .
      l) Turn on the V.A.C Ulta and select Prevena Incision Management System.
      m) The RN can turn off the disposal unit by pressing and holding to power button for 15 seconds.
      n) Disconnect the tubing by twisting the tubing at the connection and attaching it to the tubing of the V.A.C. Ulta Hospital unit.
      o) Press Start and the unit will immediately compress the pad and place dressing.

p) The V.A.C. Ulta has preset settings for the incision management which is 125 mmHg continuous.
q) The RN can then release the canister and dispose of it in a biohazard red bag.
r) The portable unit can then be placed back in the Prevena incision management carrying bag.
s) Upon discharge, if the 7 days has not finished, the portable unit can be reattached to the patient.
t) The patient can then follow up with care on day seven for removal of the incisional dressing.
u) After 192 hours of portable therapy or seven days after the application of therapy the R.N. at the bedside can remove the peel and place dressing. The closed incision can be left open to air unless otherwise indicated by a Physician order.
v) Dispose of dressing and unit in a biohazard red bag.
w) The Prevena incision management system dressing contains silver.

2. Suction:
   a. Suction will be maintained for at least 22 hours of each 24-hour period. If suction is off for more than 2 hours in any 24-hour period (verify by checking therapy history), the dressing must be removed and replaced.
      i. If a V.A.C. dressing is unable to be re-applied, a wet to dry dressing to the site is an alternative dressing until the V.A.C. dressing can be applied. Do not leave a V.A.C. dressing in place with the machine turned off for over 2 hours. Notify Physician.
   b. Suction will be set at 125 mmHg continuous unless otherwise specified by physician. After the first 48 hours V.A.C. pressure settings may be titrated up or down by 25 mmHg in the following situations:
      i. Titrate up (maximum setting is 175 mmHg) in a wound that has an excessive amount of drainage, a large wound, when V.A.C. Vers-Foam is in wound, or difficulty maintaining seal.
      ii. Titrate down (minimum setting is 50 mmHg) in wound that is very painful, or for a patient that is elderly, nutritionally compromised, on anticoagulants, has compromised circulation, or excessive granulation tissue growth.
   c. Intermittent suction therapy should be considered after the first 48 hours of therapy to stimulate granulation tissue quicker. It should not be used for patients who:
      i. Are experiencing significant pain.
      ii. Are experiencing difficulty maintaining seal.
      iii. Have wounds where tunnels or undermining exists.
      iv. Have a large or excessive amount of drainage.
      v. Are using the V.A.C. Ulta with VeraFlo (instillation therapy) option.
3. Dressing change:
   a. Pre-medicate patient per physician's order (if indicated) 60 minutes prior to dressing change for oral medication or 5 - 15 minutes prior for IV medication.
   b. Ensure V.A.C. canister and machine are at bedside.
   c. Gather all supplies for dressing change including
      i. Correct size and type of foam in unopened sterile package
      ii. Scissors
      iii. Sterile Normal Saline
      iv. Skin barrier
      v. Drape
      vi. Gloves
      vii. Gown or eye protection if necessary
      viii. Wound V.A.C. dressing kit

ix. Biohazard bag

d. Perform hand hygiene and don gloves.

e. Clamp tubing to T.R.A.C. pad and canister and remove old dressing and dispose of in biohazard bag along with gloves.
   i. If there is difficulty removing dressing, use adhesive remover.
   ii. If foam adheres to wound, use Normal Saline or sterile water to saturate the foam before removing.
   iii. If wound is extremely painful and foam is difficult to remove, consider placing a single layer of non-adherent dressing (i.e. Adaptic, mepitel) in the wound bed prior to foam placement. Do not place Xeroform in bed of wound (petroleum based).

f. Perform hand hygiene and don new gloves.

g. Cleanse wound with Normal Saline or per physician order.

h. Clean and dry skin surrounding wound.

i. Apply barrier to intact skin surrounding wound. If a patient has fragile skin, is at risk for breakdown or if breakdown exists, place thin hydrocolloid (i.e. Duoderm) to that area.

j. Assess wound:
   i. Location
   ii. Type of wound
   iii. Measure wound margins and note and measure any tunneling or undermining. including length, width and depth
   iv. Drainage
   v. Surrounding skin integrity
   vi. Odor
   vii. Appearance of wound (i.e., granulation), any tunneling or undermining
   viii. Take photograph at least weekly (during a dressing change) and upload to EHR.

k. Ensure proper foam has been chosen and cut foam to fit gently into wound.
   i. Do not cut foam directly over wound to ensure loose edges do not fall into wound.
   ii. Rub edges after cutting to remove any loose pieces.
   iii. If exposed internal organ or tendon, use a contact layer (i.e. Adaptic, mepitel) before foam application
   iv. If the wound is larger than the largest piece of foam, use more than one piece of foam ensuring that edges of foam are in direct contact with each other for even distribution of negative pressure.

l. Place foam gently into wound.
   i. Do not force foam into wound.
   ii. Foam should be slightly smaller than wound and should never lie on or touch intact skin.
   iii. For a shallow wound, foam may be thinned to accommodate smaller dimensions.
   iv. Fill in all dead space.
   v. Ensure proper count of foam inserted in wound.

m. Cut drape larger than the wound allowing for a 3 - 5 cm border.

n. Place drape over foam.
   i. Save extra drape, excess drape can be used to reinforce difficult to seal areas.
   ii. If hydrocolloid (i.e. Duoderm) has been placed ensure that the drape covers foam and the hydrocolloid (i.e. Duoderm).

o. Cut a hole into the drape the size of the T.R.A.C. pad, it is not necessary to cut into foam.

p. Apply T.R.A.C. pad directly over the hole in the drape.
   i. Do not cut the T.R.A.C. pad off or insert tubing into the foam, this will cause unit to alarm when turned on.

q. Connect dressing tubing to canister tubing and open both clamps.

r. Time, date, and sign dressing. Document properly.

s. Remove gloves and perform hand hygiene.
t. Place V.A.C. unit on a level surface, hang from the foot of the bed, or secure on an IV pole.
u. Turn on green power switch on left side of V.A.C. unit. Access V.A.C. settings under Therapy on main menu and set per physician order or on 125 mmHg continuous.
v. Press therapy on/off button to activate V.A.C. therapy.
w. In less than one minute the dressing should collapse into wound. If difficulty exists in maintaining vacuum or foam does not collapse, reinforce any air leaks with excess drape or gently press around foam with fingertips.

4. Canister Change
a. V.A.C. canister should be changed when full, on average 3 - 5 days (unit will alarm).
b. Turn off therapy and close dressing clamp and canister clamp.
c. Disconnect canister tubing from dressing tubing.
d. Remove canister from unit by pressing blue button on front of unit and pulling. Dispose of old canister in biohazard bag.
e. Insert new canister into slot and connect to dressing tubing. Open both clamps and resume therapy.
i. V.A.C. Ulta with VeraFlo (instillation therapy) requires more frequent changing of canisters due to the volume of wound irrigation solution and exudate removal.

5. Disconnecting unit for brief periods
a. If patient needs to be disconnected, ensure V.A.C. therapy is not off for more than 2 hours total in a 24-hour period.
i. Do not turn off or disconnect V.A.C therapy if wound V.A.C. in place to hold down a split thickness skin graft.
b. Turn unit off.
c. Clamp canister and dressing clamp.
d. Disconnect canister tubing from dressing tubing and cover both ends with gauze or a glove and secure.
e. To reconnect, remove gauze or glove from both ends and connect.
f. Open both clamps and turn therapy on. Unit will default to previous settings.
g. Reconnect V.A.C. unit to battery charger and wall plug. Check screen, battery symbol should be lighted green at all times.

E. TROUBLESHOOTING:

1. Active bleeding
a. If active bleeding develops suddenly or in a large amount during V.A.C. Therapy, or if bright red blood is seen in the tubing or in the canister, immediately stop the V.A.C. Therapy.
b. The RN should leave the dressing in place for the physician to remove.
c. Notify the physician immediately
d. Take measures to stop the bleeding.

2. Audible Alarms
a. Therapy is not activated.
i. Machine will alarm every 15 minutes if on when therapy is not activated.
ii. Press therapy on main screen and turn on.
b. Canister is full
i. Change canister.
ii. Even if canister does not appear to be full, or is new, and alarm goes off, check all connections then change canister, it may be faulty.
c. Leak or difficulty maintaining suction
i. Check for and listen for leaks in drape
ii. Reinforce as necessary
d. Tubing blocked
i. Ensure no kinks in tubing.

ii. Ensure clamps are open.
iii. Check that the canister is pushed fully in to the unit.
iv. Ensure that T.R.A.C. pad is not clogged. Cut out old T.R.A.C. pad. Ensure hole in drape is cut the size of a quarter. Then, replace with new T.R.A.C. pad.

e. Low battery
i. Check all connections to ensure battery charger is connected to wall plug and to the back of the V.A.C. unit.
ii. Battery symbol on screen should always be lighted and green.

f. Keep unit on flat surface, unit will alarm if tilted greater than 45 degrees.
g. Question mark at bottom left of main screen has an on-site user guide.
h. A referral may also be made per physician order to Wound Nurse for Wound Evaluation and Treatment. For other troubleshooting tips, the Skin/Wound Team is available at extension 3793 or by cell phone760-851-9903. KCI is available 24 hours a day at 1-800-275-4524

F. **DOCUMENTATION:**

1. Document in the EHR:
a. Wound V.A.C. therapy
i. Document wound output in the intake and output section of the EHR per Standards of Care
ii. For V.A.C. Ulta with VeraFlo (instillation therapy):
1) Document instillation (irrigation solution) in the electronic medication administration record (eMAR).
2) Instillation (irrigation solution) will not be calculated in the overall intake

b. Each dressing change including:
i. Photograph of wound at least weekly
ii. Wound assessment
1) Number of foam pieces removed and number of foam inserted in the wound.

G. **REFERENCE(S):**

1. KCI V.A.C Therapy System Safety Information
2. V.A.C. Therapy Clinical Guidelines A reference source for clinicians
3. Prevena Incision Management System Patient Guide

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
Patient Care

ISSUE DATE: **NEW**

SUBJECT: ~~**Delivery of the**~~ **Conditions of Admission Consent Form Delivery**

REVISION DATE:

POLICY NUMBER: **8610-NEW**

Administrative Content Expert Approval:	**10/23**
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Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure the standard Conditions of Admission (COA) form is appropriately communicated and signed by the patient or their authorized representative at time of admission to Tri-City Medical Center (TCMC). The COA form serves as the initial consent for treatment at Tri-City Medical Center and other consents may be obtained depending on the context of care.

B. **POLICY STATEMENT:**

1. Consent is necessary prior to any treatment or procedure, except in emergency situations. All facility admissions require the COA form signed by the patient or their authorized representative at the time of each hospital outpatient visit or bedded admission encounter.
2. For recurring hospital outpatient accounts, this form is required to be obtained at the initial visit of a treatment plan and/or after periods of more than 90 days between services for ongoing treatment.
3. The contents of the COA form are reviewed by patient access staff with the patient and/or the patient's authorized representative during the admission process.
4. The patient's or authorized representative's signature is obtained confirming consent for care, receiving a Patient Rights and Responsibilities, knowledge of billing information, and receipt of the Notice of Privacy Practices. The patient or their representative may be referred to appropriate administrative or clinical staff with questions about the COA form.
5. Changes to the COA form are not permitted.
6. Patient Access staff are responsible for explaining the contents of Conditions of Admission form and obtaining appropriate signatures, and proper labeling and scanning the form into the electronic **health** ~~**medical**~~ record (EHMR) (if appropriate).
7. In the event a signature cannot be obtained at admission, a TCMC staff member will indicate the reason on the COA and follow-up will occur to ensure that each patient's **health**~~**medical**~~ record contains a signed Conditions of Admission form.

C. **DEFINITIONS:**

1. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose**

conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

~~2. Employees include TCHD officers, directors, employees, independent contractors, medical staff members and volunteers while performing services on behalf of or acting within the scope of their employment or duties for TCHD.~~

D. **PROCEDURES:**

1. Obtaining consent for COA form:
   a. The following steps are performed at the time of registration. These steps may also be performed on the unit if the patient is admitted directly to a room.
      ~~b.~~**i.** During admission, a Patient Access staff member reviews the Condition of Admission form with the patient or the patient's authorized representative.
   ~~c.~~**b.** Points to emphasize during COA review:
      i. Consent to receive medical care from the providers at Tri-City Medical Center.
      ii. If a staff member is accidently exposed to your blood or body fluids, you give consent to be tested for certain viruses so caregivers can be quickly treated.
      iii. The physicians are independent contractors. The hospital participates in the training of healthcare personnel.
      iv. TCMC is not responsible for personal items or valuables.
      v. Weapons, drugs, tobacco, and prohibited behaviors are not permitted on TCMC property.
      vi. Medical information may be disclosed to your insurance plan(s) for payment.
      vii. The patient may receive bills from other providers associated with their care at a Tri-City Medical Center facility.
      viii. The Notice of Privacy Practices brochure is offered to the patient and/or their representative to keep.
      ix. Patient Rights and Responsibilities information is offered to the patient and/or their representative.
      x. Changes to the COA form are not permitted.
      xi. The patient or their authorized representative signs COA form.
2. If no signature can be obtained at admission
   a. If patient is unable to sign COA form and no authorized representative can be reached at admission, then TCMC staff members will indicate the reason on the COA.
   b. Patient Access staff will make multiple attempts to communicate the content of the COA form and have the patient sign and/or reach their authorized representative for signature. Such attempts are documented in the Encounter Notes in the EHMR.
   c. During the attempts to gain a signature, Patient Access will continue to seek a signature until such time the patient is discharged. If patient is discharged without COA signed, clinical information in the chart should reflect the urgency of the admission and the patient's inability to receive COA communication throughout their encounter.
   d. Access staff may also seek assistance of the clinical unit staff to help obtain the COA signature.
3. Patient or patient's authorized representative guidelines
   a. In the event that a patient is not able to sign upon admission or is a minor who cannot consent for themselves, follow California Hospital Association (CHA) Consent guidelines to determine if the person with the patient meets criteria as a legal representative.
4. Follow CHA Minor Consent Guidelines to determine if a minor presenting for services is able to consent for themselves or consent is needed from an authorization representative.
5. If verbal consent is received from the patient or their authorized representative it must be documented on the COA form including the date, time and relationship to patient. The COA will be witness by two TCMC employees and documented in the Encounter Notes in the EHMR system.

E. **RELATED DOCUMENTS:**

1. Conditions of Admission (COA) form

2. **Patient Care Services Policy:** Patient Rights and Responsibilities
3. **Administrative Policy:** Notice of Privacy Practices **518**
4. **Administrative Policy:** Non-Retaliation **for Reporting Compliance Issues or Suspected Misconduct 560**

F. **REFERENCE(S):**

1. 45 C.F.R. parts 160 and 164
2. California Civil Code Section 56 et. seq.
3. California Health & Safety Code Section 123222.1
4. California Hospital Association Consent Manual

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
PATIENT CARE

ISSUE DATE: 06/11 **SUBJECT:** Event Reporting

REVISION DATE~~(S)~~: 08/15, 04/19 **POLICY NUMBER:** 8610-396

Administrative Patient Care Content Expert Approval:	~~10/18~~07/23
Administrative Policies & Procedures Committee Approval:	~~02/19~~10/23
Medical Executive Committee Approval:	~~03/19~~02/24
Administration Approval:	~~04/19~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD) has a software system to track, trend, and respond to events that may have an impact, or potential impact, on patients, visitors, employees, and or medical staff. Reporting and responding to these occurrences is a process engaged to objectively and systematically monitor and evaluate quality and appropriateness of patient care. This helps to identify areas or events of concern and timely resolve quality and risk issues on an ongoing basis. This will improve the quality of patient care, patient safety, and potentially reduce health care costs and liabilities. These reportable events include unusual occurrences, adverse events, near misses, and sentinel events.

B. **DEFINITIONS:**

1. Adverse Event: An occurrence that causes the death or serious disability of a patient, personnel, or visitor, and as listed in Section 1279.1 of the California Health and Safety Code. Events listed in this section of law represent only a portion of events that should be entered into the on-line event reporting system.
2. Near Miss Event: an unplanned event that did not result in injury, illness, damage or death but had the potential to do so. Only a fortunate break in the chain of events prevented the event from occurring.
3. ~~RL Solutions (RL): Third party vendor whose software we use for reporting unusual occurrences, near misses, adverse events, sentinel events, and patient complaints.~~
4. ~~3.~~ Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. The phrase "or the risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.
5. ~~4.~~ Software System Event Reporting: An online system designed to collect data/information regarding events that may have an impact or potential impact on patients, visitors, employees, medical staff. This software is for, but not limited to, reporting of employee injuries, patient compliments and complaints, medication errors, clinical misadventures, and near misses. The event report is legally privileged information and typically exempt from discovery pursuant to applicable law.
6. ~~5.~~ Unusual Occurrence: Any event that deviates from regular operations or standards and results in, or could have resulted in (near miss), an adverse outcome for patients, staff, or visitors.
7. ~~6.~~ Workforce Member: Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, **Business Visitors, Covered Contractors** 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.

C. **POLICY:**

1. All workforce members at TCHD are responsible for participating in the identification of reportable events including near miss events and reporting via the event reporting software.
   a. The employee who is most closely involved or discovers an event or concern, should complete an event report with as much detail about the event as possible.
   b. Medical Staff members can initiate an event report by contacting the Medical Staff office Quality Coordinator or by entering the event themselves utilizing the event reporting software.
   c. All non-TCHD employees (i.e. travelers, registry, and contracted service individuals) will report events up through their chain of command for entry in the event reporting software.
2. The event report should:
   a. Be timely, objective, informative, and factually describe what happened as well as any follow-up that was done.
   b. Not be left unattended, copied, shared with a patient, ~~or~~ visitor **or anyone who does not have the need to know**, filed or referenced in the employee's personnel file, or removed from premises without the express consent of either the Risk or Legal Department.
   c. Not be a part of the medical record and shall not be referenced in the medical record at any time. The event may be recorded in the medical record as appropriate.
3. Events that should be immediately brought to the attention of the Risk Manageme**nt**~~r~~ and or **Administrative**~~House~~ Supervisor as necessary include but are not limited to:
   a. Sentinel events and other high level concerns.
      i. If the event occurs after office hours or on weekends, the Administrator on-call will determine whether or not to contact Risk Management.
      ii. Entry of the event report should not delay or interfere with appropriate clinical care or intervention.
      iii. Department leadership will perform an investigation on any occurrence that is identified as a potential risk. Risk Management will assist with complex investigations including root cause analyses. Documentation of this follow-up will be entered into the event reporting software.
   b. Any events involving actual or alleged criminal activity including, but not limited to, abuse, neglect, battery, assault, sexual misconduct, or mistreatment of patient or staff.
      i. A police report should also be filed as appropriate.
      ii. Risk Management or their designee will convene a team of individuals as necessary to investigate, take action and follow-up.
         1) Mandatory reporting will be done in collaboration with the Regulatory Department.
4. When an event occurs, the workforce member will:
   a. Perform the necessary interventions to support and optimize the patient's clinical condition
   b. Notify the patient's attending physician.
      i. Notification of the physician and any new orders as a result of an event will be documented in the patient's electronic health record (EHR)
   c. Preserve any information related to the event including physical evidence
   d. Document the facts regarding the event both in event reporting system and the EHR as indicated
5. All event reports are automatically routed to the leadership of the area in which the event occurred and simultaneously to Risk Management for assessment. Risk Management routes the file to any additional appropriate recipients who did not receive the file via automated routing.
   a. If the Medical Staff Quality Coordinator believes that the event requires peer review or other Medical Staff action, the Coordinator may share a summary of the event, but not the event report itself, with the appropriate Medical Staff officer, committee, or department in accordance with Ongoing Professional Practice Evaluation/Peer Review Process 8710-509.

D. **PROCEDURE:**

1. Log into the software on the TCHD Intranet to report an event.
   ~~a. Enter employee number as the Username and "rl" as the Password.~~
   ~~b.~~**a.** Complete all mandatory information fields. The mandatory fields have a green asterisk next to them.
   ~~c.~~**b.** Additional documents may be attached/uploaded to the file in a section labeled attachments found on every reporting template.
   ~~d.~~**c.** After completing all required fields, left click the green "Submit Button" in the lower right hand corner of the template. Staff will receive a file number which has been assigned to the event.
2. File managers' responsibilities:
   a. The Director or designated manager must acknowledge receipt of the file and follow-up within 72 hours of receipt. The file should be closed out within 7 days of entry with the exception of events requiring complex or extensive investigation.
3. Risk Management responsibilities:
   a. Risk Management will coordinate necessary actions after the completion of the investigation.
   b. Risk Management may initiate a hold on the billing associated with an adverse clinical event until such time as a determination may be made as to whether or not the patient and or their insurance should be billed for the care at issue. Events that trigger a billing hold must be resolved within 45 days for timely action by financial services.
   c. Risk Management is responsible for forwarding physician-specific events to the Medical Staff office. The Medical Staff office determines whether or not the event will be subject to one or more means of formal review.
   d. Event report data will be analyzed and monitored to identify patterns or trends in order to optimize patient safety and the delivery of consistently high quality patient care. Proper analysis will result in corrective action instituted to reduce the probability of occurrence or recurrence. Employees and medical staff are encouraged to recommend improvements related to events reported in the software.
   e. If Risk Management determines an event requires a Root Cause Analysis (RCA), Risk Management will convene a team for that purpose. The RCA process will include thorough event investigation, group analysis of the event, and creation of an action plan to reduce risk and measure progress.

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

1. Administrative Policy: Assault and Battery Reporting Process 8610-241
2. Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275
3. Administrative Policy: Mandatory Reporting Requirements 8610-236
4. Medical Staff Policy: Ongoing Professional Practice Evaluation/Peer Review Process 8710-509
5. Patient Care Services Policy: Assault Victims/Domestic Violence Reporting Requirements
6. Patient Care Services Policy: Patient Complaints and Grievances
7. Patient Care Services Policy: Reporting Suspected Child Abuse/Neglect
8. Patient Care Services Policy: Reporting Suspected Dependent Adult/Elder Abuse/Neglect
9. Reporting of and Responding to Unusual Occurrences

F. **REFERENCE(S):**

1. California Evidence Code 1156
2. The Patient Safety and Quality Improvement Act of 2005
3. California Health and Safety Code 1279.1
4. California Hospital Association Consent Manual (**2023**~~2017~~)

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 10/02 **SUBJECT:** Business Associate Agreement

REVISION DATE: 12/02; 06/06; 07/09, 06/15 **POLICY NUMBER:** 8610-511

Administrative Compliance Content Expert Approval:	~~03/19~~01/23
Administrative Policies & Procedures Committee Approval:	~~03/19~~03/23
Organizational Compliance Committee Approval:	~~05/19~~03/24
Medical Executive Committee Approval:	n/a
Administration Approval:	03/24
Audit, Compliance & Ethics Committee Approval:	~~10/19~~ n/a
Board of Directors Approval:	10/19

A. **PURPOSE:**

1. The purpose of this policy is to outline the criteria for a business associate and establishes criteria for disclosing protected health information to a business associate, including the required content of a Business Associate Agreement.

B. **DEFINITIONS:**

1. Business Associate: A person or organization who, on behalf of Tri-City Healthcare District (TCHD), performs certain functions or activities or services that require the Business Associate to create, receive, maintain or transmit protected health information (PHI) on behalf of TCHD or where TCHD needs to disclose PHI to Business Associate for services.
2. Business Associate Agreement (BAA): An Agreement, Contract or Addendum to an applicable Contract or Services Agreement between TCHD and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of TCHD PHI.
3. Covered Entity: Includes health care providers like TCHD that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing, reference laboratories). See HHS.gov. for further definitions: Covered Entities and Business Associates | HHS.gov
4. Data Use Application: Describes the purpose, controls and safeguards agreed to by the Business Associate and Covered Entity.
5. Designated Record Set: Those documents whether maintained in paper, film or electronic formats, that comprise the individual patient's medical record as approved by the Medical Executive Committee, that comprises the individual patient's billing records, and any documents used in whole or in part by TCHD to make decisions about individuals, including copies from another health care provider's Designated Record Set.
6. Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in paper, electronic, or other form that is created or received by TCHD and
   a. Relates to the past, present, or future physical or mental health or condition of an individual.
   b. Relates to the provision of health care to an individual
   c. Relates to the past, present, or future payment, and
   d. Identifies the individual or
   e. With respect to which there is a reasonable basis to believe the information can be used, to identify the individual
7. Services Agreement/and or Contract: An agreement between TCHD and a third party whereby the third party performs a function, activity or service on behalf of TCHD. Services Agreements

that require TCHD to disclose PHI for such functions, activities or services require Business Associate Agreements and/or Addendums.

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

C. **POLICY:**

1. A Business Associate is subject to civil and criminal penalties under Sections 1176 and 1177 of the Social Security Act and is directly liable for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.
2. TCHD and each Business Associate shall protect the privacy and provide for the security of PHI disclosed to Business Associate in compliance with the HIPAA Regulations.
3. If TCHD enters into a Services Agreement with a party that is a Business Associate under HIPAA, TCHD will enter into a BAA with such party before disclosing PHI to it.
4. TCHD will require that Business Associates ensure that agreements with subcontractors that receive, maintain or transmit PHI on behalf of the Business Associates for purposes of Business Associates' BAAs with TCHD are subject to the same requirements as those in TCHD's BAA.
5. TCHD also complies with and requires its Business Associates to comply with applicable state laws and regulatory requirements that may be more stringent than HIPAA, such as those requiring notification of breaches of PHI.

D. **PROCESS**:

1. As part of the HIPAA Regulations, the Privacy Rule requires TCHD to enter into a contract containing specific requirements with Business Associate prior to the disclosure of PHI. These requirements include, but may not be limited to the following:
   a. In conjunction with TCHD, Business Associate must establish the permitted Uses and Disclosures of PHI by the Business Associate. HIPAA permits the use of PHI for proper management and administration.
   b. Business Associate must refrain from using or disclosing the PHI other than as permitted by the BAA or as required by law.
   c. Business Associate must use appropriate safeguards to prevent Use or Disclosure of the information other than as provided for in the BAA.
   d. Business Associate shall have implemented a security program that includes administrative, technical and physical safeguards designed to prevent unauthorized Use or Disclosure of electronic PHI as required by the Security Rule set forth in subchapter C of Part 45.
   e. Business Associate must report to ~~the District~~**TCHD** any Use or Disclosure of PHI not provided for in the BAA or any unauthorized or unlawful access, any security incident and/or breach of PHI.
   f. Business Associate must ensure that agents and subcontractors that receive PHI from the Business Associate agree to the same restrictions and conditions that apply to the Business Associate.
   g. Business Associate shall cooperate with TCHD in fulfilling requests by individuals for access to their PHI that are approved by TCHD. If Business Associate maintains PHI received from TCHD in a Designated Record Set, Business Associate must make available that information in order to comply with an individual's right to access, inspect, and copy their health information.
   h. If Business Associate maintains PHI in a Designated Record Set, it must also provide that information in accordance with an individual's right to have ~~the District~~**TCHD** make amendments to PHI.
   i. Business Associate must provide information required to make an accounting of disclosures of PHI, where such disclosures were made for purposes not related to treatment, payment, and healthcare operations.

j. Business Associate must agree to make its internal practices, books and records related to the Use and Disclosure of PHI received from or created for TCHD available to the U.S. Department of Health and Human Services (HHS) for the purpose of determining TCHD's compliance with HIPAA.

k. Business Associate must return or destroy all PHI in any form at the termination of the Agreement, unless there is a determination that return or destruction is infeasible pursuant to the HIPAA Regulations.

l. The Business Associate Addendum shall authorize termination of it by TCHD if TCHD determines that the Business Associate has violated a material term of the Business Associate Agreement and/or Addendum.

2. The Legal Department or designee responsible for Services Agreements will determine the need for a BAA. These individuals will determine if the proposed agreement meets the following criteria:
   a. The outside entity or individual is not a TCHD Workforce Member;
   b. The outside entity or individual will perform a service or activity "for" or "on behalf of" the District; and
   c. The services or activities of the outside entity or individual involve creating, receiving, maintaining or transmitting PHI.
   d. Ascertain whether the contract involves a covered entity.
3. A TCHD-approved standard HIPAA Business Associate Agreement and Addendum, or a version thereof, must be executed.
4. When required, Business Associate and TCHD will also execute a Data Use Application.
5. The Legal Department or designee responsible for Services Agreements, will ensure that a HIPAA Business Associate Agreement and/or Addendum is executed concurrently with execution of each new Services Agreement between TCHD and a party that is identified as a Business Associate and before any PHI is disclosed by TCHD or used, created or transmitted by the Business Associate on behalf of TCHD.
6. The executed HIPAA Business Associate Agreement and/or Addendum is filed with the original Services Agreement in TCHD's Administrative Offices.
7. ~~3.~~ Best practice is to conduct annual review of BAA in order to keep up to date on rules and regulations by the Privacy Officer.

E. **FORM(S):**
1. Business Associate Agreement
2. HIPAA Business Associate - Data Use Application
3. ~~HIPAA Business Associate Addendum~~

F. **RELATED DOCUMENT(S):**
1. Instructions - Data Use Application

G. **EXTERNAL LINK(S):**
1. Covered Entities and Business Associates | HHS.gov - https://www.hhs.gov/hipaa/for-professionals/covered-entities/index.html

H. **REFERENCE(S):**
1. 45 Code of Federal Regulations (CFR) Section 164.524
2. 45 CFR Section 164.526
3. 45 CFR Section 164.528
4. 45 CFR Section 164.530
5. 45 CFR 160.103.

Tri-City Medical Center

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made a part of any and all agreements entered into by and between Tri-City Healthcare District, a healthcare district organized under the Local Healthcare District Law of the State of California, and _____, Business Associate ("BA"). This BAA shall become effective on the date executed below.

SECTION 1. RECITALS

A. TCHD is a "Covered Entity" as defined under 45 C.F.R. §160.103.
B. TCHD and BA are entering into or have entered into, and may in the future enter into, one or more agreements (each an "Underlying Agreement") as a BA of TCHD. This BAA shall only be operative in the event and to the extent this BAA is incorporated into an Underlying Agreement between TCHD and BA.
C. TCHD and BA desire to protect the privacy and provide for security of PHI used by or disclosed to BA in compliance with the HIPAA Rules (Privacy, Security, Breach Notification and Enforcement Rules).
D. This BAA is binding on all TCHD clinics (collectively known as "TCHD").

SECTION 2. DEFINITIONS

A. Tri-City Healthcare District (TCHD) includes the following entities: Tri-City Medical Center and outpatient clinics, Tri-City Wellness Center outpatient clinics, Tri-City Primary Care and Orthopedic Specialists of North County.
B. Business Associate (BA) is a person or organization who, on behalf of TCHD, performs certain functions or activities or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of TCHD or where TCHD needs to disclose PHI to Business Associate for the services as defined under 45 C.F.R. §160.103.
C. Business Associate Agreement (BAA) shall have the same meaning as an Agreement, Contract or Addendum to an applicable Contract or Services Agreement between TCHD and a BA that outlines the specific obligations of the BA related to the Use or Disclosure of TCHD PHI.
D. Health Insurance Portability and Accountability Act of 1996 (HIPAA), the regulations promulgated thereunder by the U.S. Department of Health and Human Services (45 C.F.R. Parts 160, 162 and 164) (HIPAA Regulations), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), California Civil Code §56 et seq., §1798,29 and §1798.82, and other applicable laws and regulations. The purpose of this BAA is to satisfy certain standards and requirements of HIPAA Regulations, including 45 C.F.R. §164.504(e), the HITECH Act, including Subtitle D, part 1, as they may be amended from time to time, and similar requirements under California law.
E. Protected Health Information (PHI) as defined in the HIPAA Regulations as that which is created, received, maintained, or transmitted by BA or any Subcontractor on behalf of TCHD and shall also include "medical information" as defined by California Civil Code §56.05.
F. Designated Record Set are documents, whether maintained in paper, film or electronic formats, that compromise the Individual's medical record, billing records, and any documents used in whole or in part by TCHD to make decisions about Individuals including copies from another healthcare provider's designated record set.
G. Unsuccessful Security Incident shall mean pings and other broadcast attacks on a firewall, port scans, unsuccessful log-on attempts, denials of service, or other similar

attempted but Unsuccessful Security Incident, or a combination thereof, so long as no such incident results in unauthorized access, Use or Disclosure of PHI.

H. Capitalized Terms used in this BAA and not otherwise defined herein shall have the meanings set forth in the HIPAA Rules, which definitions are incorporated in this BAA by reference.

SECTION 3. OBLIGATIONS OF BA

A. Comply with the requirements of the Privacy Rule that apply to TCHD in carrying out such obligations, to the extent BA carries out any obligations of TCHD under the Privacy Rule. BA also agrees to comply with the applicable requirements of California state privacy laws and regulations that apply to TCHD in carrying out such obligations, to the extent BA carries out any obligations of TCHD under California Civil Code §1798 et seq., California Civil Code §56 et seq., and California Health and Safety Code §1280.15 and §1280.18, as applicable, unless otherwise mutually agreed to by BA and TCHD.

B. Not use and disclose PHI other than as permitted or required by the Underlying Agreement or as Required by Law. A BA is directly liable under certain provisions of the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making Uses and Disclosures of PHI that are not authorized by its contract or Required by Law.

C. Use appropriate safeguards, and comply where applicable with 45 C.F.R. §164 Subpart C with respect to ePHI, to prevent the Use or Disclosure of PHI, including implementing of the HIPAA Security Rule with regard to ePHI, other than as provided for by the Underlying Agreement(s) and the BAA. A BA is also directly liable and subject to civil penalties for failing to safeguard ePHI in accordance with the HIPAA Security Rule (Omnibus Rule).

D. Notify TCHD's Chief of Compliance and Privacy Officer, in writing, promptly, but in no event more than five (5) business days, after BA becomes aware of any Use or Disclosure of the PHI not permitted or required by the BAA or Underlying Agreement(s), including Breaches of unsecured PHI as required by 45 C.F.R. §164.410 (each, collectively an "Incident"), provided, however, that the Parties acknowledge that this Section constitutes notice by BA to TCHD of the ongoing existence and occurrence of Unsuccessful Security Incidents. BA shall be deemed to be aware of any such Incident, as of the first day on which it becomes aware of it, or by exercising reasonable diligence, should have been known to its officers, employees or subcontractors. The notification to TCHD shall include, to the extent possible, each Individual whose unsecured PHI has been, or is reasonably believed by BA to have been, accessed, acquired, used or disclosed during such Incident. BA will handle Breach notifications to affected Individuals, the HHS Office for Civil Rights (OCR), California Department of Health Services (CDPH), and potentially the media, on behalf of TCHD. BA shall take prompt corrective action to remedy such Incident, and, promptly, shall provide to TCHD in writing: (i) the actions initiated by the BA to mitigate, to the extent practicable, any harmful effect of such Incident; and (ii) the corrective action BA has initiated or plans to initiate to prevent future similar Incidents.

E. Ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of the BA agree to the same restrictions, conditions, and requirements that apply to the BA with respect to such PHI.

F. If BA maintains PHI in a Designated Record Sect, BA shall make the PHI in the Designated Record Set available to TCHD pursuant to 45 C.F.R. §164.524 within ten (10) business days from the date requested.

G. If BA maintains PHI in a Designated Record Set, BA shall make any amendments directed or agreed to by TCHD pursuant to 45 C.F.R. §164.526, or take other measures as necessary to satisfy TCHD obligations under 45 C.F.R. §164.526.

H. Maintain and make available to TCHD, within ten (10) business days, the information

required to provide an accounting of disclosures, as necessary to satisfy TCHD's obligations under 45 C.F.R. §164.528.

I. Make its internal practices, books, and records, relating to the Use and Disclosure of PHI available to the Secretary for purposes of determining TCHD's compliance with HIPAA, HITECH and their implementing regulations. 45 C.F.R. §164.504 (e)(2)(ii)(I).

SECTION 4. PERMITTED USES AND DISCLOSURES BY BA

A. BA may only use or disclose the Minimum Necessary, as set forth in 45 C.F.R. §164.502(b), to perform the services set forth in the Underling Agreement or as Required by Law.
B. BA may not use or disclose PHI in a manner that would violate Subpart E of 45 C.F.R. Part 164 if done by TCHD.
C. BA may use and disclose PHI for the proper management and administration of BA or to carry out the legal responsibilities of the BA, provided the Disclosures are Required by Law or BA obtains reasonable assurances from the person or entity to whom the information is disclosed, that the information will remain confidential and used or further disclosed only as Required by Law or for the purposes of which it was disclosed to the person or entity, and the person or entity notifies BA of any instances of which it is aware in which the confidentiality of the information has been breached.
D. Except as otherwise limited in this BAA, BA may use PHI to provide Data Aggregation services as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).
E. BA may de-identify PHI in accordance with the standards set forth in 45 C.F.R. §164.514(b) or create a Limited Data Set and use or disclose: (1) de-identified information in a manner consistent with and permitted by HIPAA; and (2) Limited Data Set information in a manner consistent with and permitted by HIPAA subject to a separate "data Use Agreement" to be entered into by the Parties.

SECTION 5. OBLIGATIONS OF TCHD

A. TCHD shall not share any information with BA in violation of California Civil Code §1798 et seq.
B. TCHD shall notify BA of any limitation(s) in its, or an applicable, Notice of Privacy Practices in accordance with 45 C.F.R. §164.520, to the extent that such limitation may affect BA's Use or Disclosure of PHI.
C. TCHD shall obtain any consent or authorization that may be required by the Privacy Rule, or applicable state law, prior to furnishing BA with PHI. TCHD shall notify BA of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect BA's Use or Disclosure of PHI.
D. TCHD shall notify BA of any restriction to the Use or Disclosure of PHI that TCHD has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect BA's Use or Disclosure of PHI.
E. TCHD shall not request BA to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by TCHD, except as permitted pursuant to the provisions of Section 5 of this BAA.

SECTION 6. TERM AND TERMINATION

A. The term of this BAA shall commence as of the BAA Effective Date, and shall terminate when all of the PHI provided by TCHD to BA or created or received by BA on behalf of TCHD, is destroyed or returned to TCHD. If it is not feasible to destroy or return PHI, BA shall extend the protections to such information in accordance with Section 6(C).
B. Termination for Cause. Either Party may termination this BAA, if upon either Party's knowledge of a material Breach by the other Party of this BAA, such Party provides written notice to the breaching Party detailing the nature of the Breach and providing

an opportunity to cure the Breach within thirty (30) business days. Upon the expiration of such thirty (30) day cure period, the non-breaching Party may terminate this BAA if the Breach Party does not cure the Breach or the cure is not possible.

C. Upon termination of this BAA for any reason, with respect to PHI received from TCHD, or created, maintained, or received by BA on behalf of TCHD, BA shall destroy or return to TCHD, at TCHD's option, all such PHI that BA still maintains in any form and retain no copies of such PHI.
D. To the extent return or destruction of TCHD PHI is not feasible, BA shall: (1) retain only that PHI that is necessary for BA to continue its proper management and administration or to carry out is legal responsibilities; and (2) continue to use appropriate safeguards for such TCHD PHI and comply with Subpart C of 45 C.F.R. Part 164 with respect to ePHI to prevent Use and Disclosure of the PHI, other than as provided for in this Section, for as long as BA retains the PHI.

SECTION 7. GENERAL

A. Amendments. This BAA may be modified, or any rights under it waived, only by a written document executed by the authorized representatives of both Parties. The Parties agree to amend this Agreement from time to time as is necessary for compliance with requirements of the HIPAA Rules and any other applicable law.
B. Interpretation. Any ambiguity in this BA shall be interpreted to permit compliance with the HIPAA Rules and Regulations.
C. Survival. The obligations of the BA under Section 6(C)-(D) shall survive the termination of this BAA and any Underlying Agreement(s).
D. Counterparts. This BAA may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.
E. Governing Law. This BAA is governed by, and shall be construed in accordance with, the laws of the State of California without respect to the conflict of laws provision thereof that would require the application of the laws of any other jurisdiction.
F. Assignment. TCHD shall not assign this BAA without prior written consent of BA, which shall not be reasonably withheld.
G. Severability. If any part of a provision of this BAA is found illegal or unenforceable, it shall be enforced to the maximum extent permissible, and the legality and enforceability of the remainder of that provision and all other provisions of this BAA shall not be affected.
H. Notice. All notices relating to the Parties' legal rights and remedies under this BAA shall be provided in writing to a Party, shall be sent to the address set forth in the Services Agreement, or to such other address as may be designated by that Party by notice to the sending Party, and shall reference this BAA.
I. Entire Agreement. This BAA is the complete and exclusive Agreement between the Parties with respect to the subject matter hereof, superseding and replacing all prior agreements, communications, and understandings (written and oral) regarding the subject matter hereof.
J. Nothing in this BAA shall confer any right, remedy, or obligation upon anyone other than TCHD and BA.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Parties have executed this Business Associate Agreement to be effective when signed by authorized representatives of both Parties.

For TRI-CITY HEALTHCARE DISTRICT	**For BUSINESS ASSOCIATE**
By: _____	By: _____
Name: Susan Bond	Name:
Title: General Counsel	Title:
Date: _____	Date: _____

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is entered into by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("HOSPITAL"), and _____ ("CONTRACTOR") (the HOSPITAL and CONTRACTOR may be referred to individually as a "Party" and collectively as the "Parties"), and is effective, as detailed within, when signed by authorized representatives of both Parties.

RECITALS

A. HOSPITAL and CONTRACTOR wish to form or have already formed a business relationship, under which CONTRACTOR may perform certain functions for or on behalf of HOSPITAL involving either or both of the Disclosure of Protected Health Information (hereafter "PHI") by HOSPITAL to CONTRACTOR and/or the creation or Use of PHI by CONTRACTOR on behalf of HOSPITAL.

B. HOSPITAL and CONTRACTOR intend to protect the privacy and provide for the security of PHI Disclosed to or Used by CONTRACTOR pursuant to this Agreement, in compliance with the Health Insurance Portability and Accountability Act of 1996 (Public Law 104.191; commonly referred to as "HIPAA"), the regulations promulgated thereunder, and other applicable laws, including without limitation the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (Public Law 111-005; commonly referred to as the "HITECH Act"), the HIPAA Final Omnibus Rule of January 2013, the California Medical Information Act ("CMIA") (CA Civil Code §§ 56-56.37), the California Information Practices Act (CA Civil Code §§ 198-1798.78), California Health & Safety Code § 1280.15, California Health & Safety Code §§ 123100-123149.5, and any statutes and regulations adopted or to be adopted in conjunction with or pursuant thereto (hereinafter, collectively referred to as the "HIPAA Rules").

C. HOSPITAL may engage in one or more enterprises governed by HIPAA regulation 45 C.F.R. § 160.103, and may require services from CONTRACTOR, the nature of which may require that PHI be Used or generated by CONTRACTOR on behalf of HOSPITAL.

D. This Agreement sets forth the terms and conditions pursuant to which PHI that is created, received, maintained, or transmitted by CONTRACTOR, from or on behalf of HOSPITAL, shall be managed. This Agreement supplements and/or amends each of the Contractual Agreements with respect to CONTRACTOR's creation, receipt, Use, and transmission of PHI thereunder, so as to allow HOSPITAL and CONTRACTOR to comply with the HIPAA Rules.

In consideration of the mutual promises below, in contemplation of the exchange of information under this or other contractual arrangements and in order to comply with legal requirements for the protection of this information, the parties agree as follows:

1. DEFINITION OF TERMS

1.1 Catch-all definition. The following terms (and any other capitalized terms not specified here), if used in this Agreement, shall have the same meaning as those terms in the HIPAA Rules: Accounting of Disclosures, Breach, Data

Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 **Agreement** means this Business Associate Agreement.

1.3 **Contractual Arrangements** shall refer to all other contracts, memoranda of understanding or agreement, or any similar instruments or oral arrangements establishing the exchange of goods or services between HOSPITAL and CONTRACTOR.

1.4 **De-identified** shall have the meaning set forth in 45 C.F.R. § 164.514(b). This definition, and the related section of the HIPAA Rules, specifies that all 18 of the PHI identifiers shall be removed. De-identified information does not constitute Protected Health Information and is not subject to the terms of this Agreement so long as the information remains separated from any information by which the Record Subject may be identified.

1.5 **HOSPITAL** shall mean the Party so named above, and shall include any members of its workforce, officers, agents, representatives and contractors.

1.6 **CONTRACTOR** shall mean the Party so named above, and any members of its workforce, officers, agents, subcontractors, representatives and affiliated contractors.

1.7 **Record Subject** shall mean the Individual who may be identified by, and who is the subject of, any record or records containing PHI.

2. RIGHTS OF CONTRACTOR

2.1 **Data Ownership:** CONTRACTOR acknowledges that he or she has no ownership interest in PHI received from HOSPITAL or created on HOSPITAL's behalf. CONTRACTOR will take no actions and make no representations that contradict this acknowledgment.

2.2 **Services:** Except as otherwise specified in this Agreement or by law, CONTRACTOR may make any and all Uses or Disclosures of PHI necessary to perform its obligations to HOSPITAL under existing or future Contractual Arrangements. All other Uses or Disclosures are prohibited. CONTRACTOR may Use or Disclose PHI for the purposes made necessary under its Contractual Arrangements with HOSPITAL only (i) to members of its workforce, contractors, and agents, in accordance with this Agreement; or (ii) as directed by the HOSPITAL.

3. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR

With regard to his or her Use and/or Disclosure of PHI, CONTRACTOR agrees to:

3.1 Use or Disclose the Minimum Necessary PHI that it receives from or creates for HOSPITAL only as permitted or required by this Agreement or as otherwise Required by Law. [164.502(a)(4)(i) and (ii); 164.504(e)(2)(i); 164.504(e)(2)(ii)(A)] This includes, but is not limited to, CONTRACTOR being able to:

a. Disclose PHI when required by the Secretary to investigate or determine the CONTRACTOR's compliance with the HIPAA Rules.

b. Disclose PHI to the HOSPITAL, Individual, or Individual's designee, as necessary to satisfy a HOSPITAL's obligations under § 164.524(c)(2)(ii) and (3)(ii) with respect to an Individual's request for an electronic copy of PHI.

c. Use the PHI in its possession for its own normal management and administration, and to fulfill any present or future legal responsibilities of CONTRACTOR, provided that such Uses are permitted under California and federal confidentiality laws.

d. Disclose the PHI in its possession to third parties for the purpose of its own normal management and administration, or to fulfill any present or future legal responsibilities of CONTRACTOR, provided that:

i. the Disclosures are Required by Law; or

ii. CONTRACTOR has received from the third party reasonable assurances that that entity will treat PHI as CONTRACTOR would under this Agreement including, where applicable, via written contract as required in 45 C.F.R. § 164.504(e)(5).

e. provide Data Aggregation services relating to the Health Care Operations of HOSPITAL. Under no circumstances may CONTRACTOR Disclose PHI of HOSPITAL to another Covered Entity absent the explicit authorization of HOSPITAL.

f. request PHI in the form of a Limited Data Set, to be used for limited research, public health or health care operations purposes.

g. De-identify PHI obtained by CONTRACTOR under this Agreement and use such De-identified data, provided that such use is in accordance with the De-identification requirements of the HIPAA Rules.

3.2 report to HOSPITAL's designated Privacy Officer any Use or Disclosure of PHI that is not permitted or required by this Agreement, and in addition, report to HOSPITAL's designated Privacy Officer any Security Incident, or any Breach (as defined in the HITECH Act or applicable state law, including without limitation section 1280.15 of the California Health & Safety Code), **within 1 day** of CONTRACTOR's discovery of such Breach, Security Incident, and/or unauthorized Use or Disclosure, with pertinent detail as this information is collected and to include the Risk Assessment performed by CONTRACTOR (and any necessary supporting information) in accordance with the HIPAA Rules included or following as soon thereafter as may be possible and mutually agreed by the Parties. [164.314(a)(2)(i)(C); 164.504(e)(2)(ii)(C); 164.410(b); 164.410(c)]

3.3 establish and act upon policies and procedures for protecting the privacy and security of PHI, including, but not limited to, contingency planning/backup and periodic security training, as required by the HIPAA Rules, and to the extent the CONTRACTOR is to carry out HOSPITAL's obligations the CONTRACTOR will comply with the requirements of 45 C.F.R., Part 164, Subpart C and Subpart E. [164.314(a)(2)(i)(A); 164.504(e)(2)(ii)(B); 164.504(e)(2)(ii)(H)]

3.4 implement administrative, physical, and technical safeguards that meet or exceed industry standards and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or

transmits on behalf of HOSPITAL, as required by the HIPAA Rules, covering at a minimum those elements of the HIPAA Rules made directly applicable to CONTRACTOR or any of CONTRACTOR's contractors. [164.504(e)(2)(ii)(B)]

3.5 ensure, through written contract or similar vehicle, that any subcontractor that creates, receives, maintains or transmits PHI on behalf of CONTRACTOR or HOSPITAL, agrees to the same restrictions and conditions that apply through this Agreement to CONTRACTOR with respect to such information. [164.314(a)(2)(i)(B); 164.504(e)(2)(ii)(D)]

3.6 make available its internal practices, books and records relating to any Use or Disclosure of PHI to the Department of Health and Human Services for purposes of determining HOSPITAL's and/or CONTRACTOR's compliance with the HIPAA Rules. [164.504(e)(2)(ii)(I)]

3.7 provide HOSPITAL any information requested by HOSPITAL, in writing, that is needed to permit HOSPITAL to respond under the HIPAA Rules to a request by a Record Subject for an Accounting of the Disclosures of PHI of the individual, **within 10 business days** of the request; the response shall be in electronic format if so required by the HITECH Act and requested by HOSPITAL, and shall cover the lesser of the timeframe specifically requested or the maximum timeframe that over which such information must be retained by HOSPITAL and/or CONTRACTOR under the applicable portion of the HIPAA Rules, in accordance with 45 C.F.R. § 164.528. [164.504(e)(2)(ii)(G)]

3.8 return to HOSPITAL or destroy, **within 20 business days** of the termination of this Agreement, all PHI in CONTRACTOR's possession and retain no copies, transcripts or backups thereof. In the event that it is infeasible to return or destroy some PHI, CONTRACTOR agrees to inform HOSPITAL in writing **within 10 business days**, and to limit further Use or Disclosure of the PHI to those purposes that make return or destruction infeasible, and to maintain the protections specified in this Agreement for any retained information, for as long as the information is retained by CONTRACTOR. [164.504(e)(2)(ii)(J)]

3.9 Use internally and/or Disclose to CONTRACTOR's contractors, agents or other third parties, and request from HOSPITAL, only the Minimum Necessary PHI to perform or fulfill a specific function permitted or Required by Law or CONTRACTOR's Contractual Arrangements with HOSPITAL, utilizing Limited Data Sets wherever feasible and practicable, as further specified in Section 3.13 of this Agreement and as required by the HIPAA Rules. [164.502(b); 164.514(d)]

3.10 defer to HOSPITAL with respect to any notifications that may be necessary, as specified in Sections 4.3 and 4.4 of this Agreement, in the event of a Breach.

3.11 allow HOSPITAL, within ten (10) business days of a written request to CONTRACTOR by HOSPITAL, to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies, and procedures of CONTRACTOR relating to the Use or Disclosure of PHI pursuant to this Agreement and the HIPAA Rule.

3.12 **With Respect to the Handling of Designated Record Sets,** CONTRACTOR further agrees to:

a. provide access to the PHI for HOSPITAL or the Record Subject to whom such PHI relates (or his or her authorized representative), at the request of, and within the timeframe designated by the HIPAA Rules and HOSPITAL, in order to meet a request by such Individual under the

HIPAA Rules, in accordance with 45 C.F.R. § 164.524. [164.504(e)(2)(ii)(E)]

b. make any amendment(s) to the PHI required by the HIPAA Rules that HOSPITAL directs, at the request of and within the timeframe designated by the HIPAA Rules and HOSPITAL, in accordance with 45 C.F.R. § 164.526. [164.504(e)(2)(ii)(F)]

3.13 **With Respect to the Use or Disclosure of Limited Data Sets**, CONTRACTOR further agrees to:

a. limit the use of the Limited Data Set to the specific research, public health, or health care operations purposes for which the data was requested;

b. make no attempt to reconstruct the identity of the Record Subject from the Limited Data Set;

c. establish in advance what entities other than CONTRACTOR may be asked by CONTRACTOR to Use or Disclose the Limited Data Set, obtain agreements from such entities to abide by the specific restrictions applicable to CONTRACTOR with respect to Limited Data Sets (as set forth in this section 3.13), and certify compliance with this section to HOSPITAL in writing.

4. OBLIGATIONS OF HOSPITAL

4.1 HOSPITAL shall not request CONTRACTOR to Use or Disclose PHI in any manner that would violate this Agreement or the HIPAA Rules.

4.2 With regard to the Use or Disclosure of PHI by CONTRACTOR, HOSPITAL agrees to notify CONTRACTOR, in writing and in a timely manner, of any arrangements or limitations permitted or required of the HOSPITAL under the HIPAA Rules that will significantly impact the Use or Disclosure of PHI by CONTRACTOR under their Contractual Arrangements, including, but not limited to, restrictions on Use or Disclosure of PHI agreed to by the HOSPITAL pursuant to a Record Subject's approved request for additional privacy restrictions.

4.3 Notification to Individual. It is the sole responsibility of the HOSPITAL to notify Individuals of any Breach of PHI. At no time, is CONTRACTOR to contact or speak directly with any of HOSPITAL's Individuals who are the subject of any Breach of PHI. Any such inquiries should be directed to the HOSPITAL's Privacy Officer. CONTRACTOR shall cooperate with HOSPITAL as necessary to provide such notification and any details pertaining to any Breach of PHI.

4.4 Notification to Media. For a Breach of PHI involving more than 500 Individuals, it is solely the responsibility of HOSPITAL to notify the media and appropriate law enforcement and federal and state agencies as required by the HITECH Act, 45 C.F.R. § 164.406, and applicable state law. At no time is CONTRACTOR to contact or speak directly with the media without the prior authorization of HOSPITAL. CONTRACTOR shall cooperate with HOSPITAL as necessary to gather information or provide such notification to the media.

5. WARRANTIES AND REPRESENTATIONS

Each Party represents and warrants to the other Party that all of its workforce members, officers, agents, representatives and contractors whose services may be used to fulfill obligations under this Agreement or other Contractual Arrangements are or shall be

appropriately informed of their responsibilities and duties with respect to PHI and the HIPAA Rules, are qualified to render those services competently and in compliance with the HIPAA Rules, and are under legal obligation to each Party, respectively, to observe and comply with all applicable medical privacy and confidentiality requirements, by contract or otherwise, sufficient to enable each Party to fully comply with all provisions of this Agreement and all other standards set by applicable federal and California law.

6. TERM AND TERMINATION

6.1 **Term.** This Agreement shall become effective when signed by authorized representatives of both Parties and shall continue in effect, unless specifically terminated as provided in this Section. In addition, certain provisions and requirements of this Agreement may survive its expiration or other termination.

6.2 **Termination by HOSPITAL.** If HOSPITAL determines that CONTRACTOR has breached a material term of this Agreement, HOSPITAL shall provide CONTRACTOR with written notice of the existence of a breach and afford CONTRACTOR an opportunity to cure said breach upon mutually agreeable terms. CONTRACTOR must provide an acceptable and effective plan to cure said breach to the satisfaction of HOSPITAL **within 10 days of** receiving notice. Failure to cure will be grounds for the immediate termination of this Addendum. [164.504(e)(2)(iii)]

6.3 **Termination by CONTRACTOR.** If CONTRACTOR determines that HOSPITAL has breached a material term of this Agreement, or that a material condition of performance under this Agreement has so changed that CONTRACTOR finds it impossible to comply with the new condition, CONTRACTOR may provide **60 days' notice** of its intention to terminate this Agreement and any related Contractual Arrangements.

6.4 **Effect of Termination.** In the event of termination pursuant to this Section, CONTRACTOR agrees to return or destroy all PHI received from or created, transmitted, or maintained for HOSPITAL as specified in Section 3.8. Further, the obligation to indemnify the other party set forth in Section 7.1 shall survive the termination of this Agreement for any reason.

In the event that CONTRACTOR determines that returning or destroying a subset of the PHI is infeasible, CONTRACTOR shall provide to HOSPITAL notification of the conditions that make return or destruction infeasible. CONTRACTOR shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as CONTRACTOR maintains such PHI.

7. INDEMNIFICATION AND INSURANCE

7.1 **Indemnification.** The Parties agree to indemnify and hold harmless each other and each other's respective employees, agents and affiliated entities against any claim, damage or liability, including reasonable defense costs, that may result from any third party claim if and to the extent proximately caused by any breach of this Agreement by the other, as determined by a court, administrative body of competent jurisdiction, formal alternative dispute resolution process or good faith negotiated settlement, and provided that the party seeking indemnification furnishes to the other prompt written notice and requisite authority, information and assistance to defend, save that the Indemnifying Party may not make any admission of fault or liability on behalf of the other without the other Party's prior written permission.

7.2 **Insurance.** CONTRACTOR, at its sole cost and expense, shall insure its activities in connection with this Agreement. Specifically, CONTRACTOR shall obtain, keep in force, and maintain insurance or equivalent programs of self-insurance with appropriate limits that shall cover losses that may arise from breach of this Agreement, breach of CONTRACTOR's security, or other unauthorized Use or Disclosure of PHI by CONTRACTOR. At HOSPITAL's request, CONTRACTOR shall provide copies of Certificates of Insurance, or other similar documentation satisfactory to HOSPITAL, prior to the effective date of this Agreement, and in such cases shall continue to update HOSPITAL with regard to changes in CONTRACTOR's chosen insurance carriers or coverage limits. It should be expressly understood, however, that the limits and coverage expressed therein shall in no way limit the liability of CONTRACTOR.

8. MISCELLANEOUS

8.1 **Amendments.** The Parties acknowledge that technology, best industry practices, and state and federal law regarding the privacy of PHI are rapidly evolving, and that amendment of this Agreement may be required to reflect such developments. Upon HOSPITAL's request, CONTRACTOR agrees to promptly enter into the negotiations with HOSPITAL concerning the terms of any necessary changes to this Agreement consistent with these developments, in order to maintain optimal privacy and confidentiality for the PHI that CONTRACTOR receives from or creates for HOSPITAL. This Agreement may not be modified, nor any provision hereof waived or amended, except in a writing duly signed by authorized representatives of the Parties.

8.2 **Assignments/Subcontracting.** This Agreement shall inure to the benefit of and be binding upon the Parties hereto and their respective legal representatives, affiliated entities, successors and assigns. CONTRACTOR may not assign the rights or obligations under this Agreement without the express written consent of HOSPITAL.

8.3 **Assistance in Litigation/Administrative Proceedings.** Upon written request of either Party, and upon making arrangement to pay reasonable expenses incurred, the Parties agree to provide good-faith assistance, in the form of records, witness testimony, and other evidence as the requesting Party may reasonably deem necessary in order to defend against a third party judicial or administrative action or investigation, provided that such assistance would not unfairly prejudice the ability of that Party to defend itself in any pending or expected legal or administrative proceeding or investigation. This clause shall not have effect in cases of adversarial proceedings between the Parties, and under such circumstances the normal rules of discovery shall instead apply.

8.4 **Attorneys' Fees.** If any legal action, suit or proceeding, including mediation, arbitration or other non-judicial proceeding, is commenced between CONTRACTOR and HOSPITAL regarding their respective rights and obligations under this Agreement, the prevailing Party shall be entitled to recover, in addition to damages or other relief, all costs and expenses, attorneys' fees and court costs (including, without limitation, expert witness fees). As used herein, the term "prevailing Party" shall mean the Party that obtains the principal relief that it has sought by judgment. If the Party that commenced or instituted the action, suit or proceeding shall dismiss or discontinue it without the concurrence of the other Party, such other party shall be deemed the prevailing Party.

8.5 **Dispute Resolution.** The Parties agree to attempt, in good faith, to resolve any breach or alleged breach that does not result in summary termination under

Section 6.2 of this Agreement. Should such attempts fail to produce a mutually agreeable result within a reasonable period of time, the Parties agree to seek mediation before a mediator approved by, and in a process conducted under the applicable rules of, the American Arbitration Association before filing a lawsuit over the unresolved matters. Notwithstanding the foregoing, the Parties waive all rights to, and agree not to assert any right to, any trial by jury on any issues or disputes arising under or related to this Agreement.

8.6 **General Interpretation.** The Parties have negotiated the terms of this Agreement and the language used in this Agreement shall be deemed to be the language chosen by the Parties to express their mutual intent. This Agreement shall be construed without regard to any presumption or rule requiring construction against the Party causing such instrument or any portion thereof to be drafted, or in favor of the Party receiving a particular benefit under the Agreement. In addition, any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

8.7 **Governing Law.** This Agreement shall be governed by the laws of the State of California. All disputes arising hereunder shall be adjudicated before the courts of the County of San Diego, California. The Parties hereby waive all objections to the exercise of personal jurisdiction or venue of said courts.

8.8 **Merger.** This Agreement and the respective Contractual Arrangements comprise the entire agreement between the Parties, with respect to the privacy of PHI and the ordering and termination of relationships that impact such concerns, and supersedes all prior discussions, negotiations, and arrangements.

8.9 **Notice**. Any notice to be given under this Agreement shall be in writing and delivered personally or sent by certified or registered mail or overnight delivery

(for HOSPITAL): Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Chief Executive Officer

(for CONTRACTOR): _____
_____
_____

8.10 **Remedies.** The right to any redress, cure, indemnification, termination, or any other right conferred under this Agreement is not intended to be exclusive and exists in addition to any other rights or remedies available to either Party at law or in equity.

8.11 **Severance.** The invalidity or unenforceability of any part of this Agreement shall not affect the remaining provisions, and the Agreement shall be construed as if the invalid provisions were omitted.

8.12 **Survival.** The respective rights and obligations of the Parties under the provisions of this Agreement, solely with respect to PHI that CONTRACTOR retains in accordance with Sections 3.10, shall survive termination of this Agreement indefinitely. All of Section 3 shall survive termination of this Agreement with respect to retained PHI that comprises some or all of a Designated Record Set.

8.13 **Third Party Beneficiaries.** Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and their respective affiliated entities, successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

8.14 **Waiver.** All rights and obligations created under this Agreement shall survive any attempt, other than through a valid Amendment as per Section 8.1, to remove or modify them. No action or failure to act by either Party, other than the execution of a valid written Amendment, may waive any right or obligation to subsequently act, refrain from acting, or command the action or inaction of the other Party, as applicable, as provided within this Agreement.

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective when signed by authorized representatives of both Parties.

For HOSPITAL		**For CONTRACTOR**	
By:	_____	By:	_____
Name:	Steve Dietlin	Name:	_____
Title:	Chief Executive Officer	Title:	_____
Date:	_____	Date:	_____

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

HIPAA Business Associate - Data Use Application

Principal Recipient of Protected Health Information

Company Name and Contact: _____

Address: _____

Phone # _____ Fax # _____

E-mail:_____

This Application is executed as part of the Business Associate Agreement, to reflect additional specifications relating to the Use or Disclosure of the Designated Data Set of Protected Health Information (PHI). This Application may be amended from time to time as needed.

1. The **purpose of the information** and how the Designated Data Set of PHI will be used to accomplish that purpose: _____

2. The **specific purpose for the use and disclosure** of this data:_____

3. Identification of **who is intended to use and receive** the data: _____

4. **Safeguards** that prevent unauthorized use or disclosure: _____

5. The **plan (how and when) to destroy** the Designated Data Set of PHI: _____

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

6. **Additional Terms.** [This section may include specifications for disclosure format, method of transmission, use of an intermediary, use of digital signatures or PKI, authentication, additional security or privacy specifications, de-identification or re-identification of data and other additional terms.] _____
_____
_____
_____
_____

7. Person Completing This Application:

Signature:_____

Print Name:_____

Title:_____

Date Signed:_____

Revised: 10/19

RETIRE – no longer needed

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA BUSINESS ASSOCIATE ADDENDUM ("**Addendum**") is entered into as of _____, 20___ (the "*Execution Date*"), by and between Tri-City Healthcare District, a health care district organized under the Local Health Care District Law of the State of California ("**Hospital**") and _____ ("**Contractor**").

A. Hospital owns and operates a general acute care hospital that is located at 4002 Vista Way, Oceanside, California.

B. Hospital is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**") and, as such, must enter into so-called "business associate" contracts with its contractors that may have access to patient medical information in either paper or electronic form.

C. Pursuant to that certain _____ Agreement by and between Hospital and Contractor, dated as of _____, 20___ (the "**Agreement**"), Contractor may have access to patient medical information from Hospital.

D. Hospital and Contractor are committed to complying with HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, Public Law 111-05 ("HITECH Act") and their implementing regulations ("the HIPAA Regulations) as they become effective or as otherwise amended from time to time (collectively these changes, HIPAA and the HIPAA Regulations shall hereinafter be referred to as the "HIPAA Laws"), the California Medical Information Act ("CMIA"), contained in the California Civil Code Section 56 *et seq.*, the Patient Access To Medical Records Act ("PAMRA") contained in the California Health and Safety Code, Section 123100 *et seq.*, California Health and Safety Code Section 1280.15 ("Section 1280.15") and other California patient privacy laws.

E. NOW, THEREFORE, in consideration of the recitals, conditions and promises herein contained, the parties do hereby agree as follows:

1. Defined Terms.

(a) Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the HIPAA Laws. A reference in this Addendum to a section in the HIPAA Regulations, means the section of the Code of Federal Regulations (CFR) as in effect or as amended, and for which compliance is required.

(b) Unauthorized or Unlawful Access shall mean the inappropriate review or viewing of patient medical information without a direct need for diagnosis, treatment or other lawful Use as permitted by HIPAA, CMIA or by other statutes or regulations governing the lawful access, Use or Disclosure of medical information.

(c) Designated Data Set is a group of records, from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the Individual, and which is used to make decisions about the Individual.

(d) Data Use Application describes the purpose, controls and safeguards agreed to by the Contractor and Hospital.

2. Billing and Collecting. If Contractor provides billing and collecting services to Hospital or otherwise conducts any Standard Transactions on behalf of Hospital, Contractor shall comply

with this Section. Contractor shall comply with 45 CFR Parts 160 and 162 (the "**Transaction Rule**"), including: (a) Contractor shall not change the definition, data condition, or use of a data element or segment in a standard of the Transactions Rule (a "**Standard**"); (b) Contractor shall not add any data elements or segments to the maximum defined data set; (c) Contractor shall not use any code or data elements that are either marked "not used" in the Standard's implementation specification or are not in the Standard's implementation specification(s); and (d) Contractor shall not change the meaning or intent of the Standard's implementation specification(s).

3. Contractor's Obligations

(a) Contractor acknowledges and agrees that all Protected Health Information that is created or received by Hospital and Disclosed or made available in any form, including paper record, audio recording, and electronic display by Hospital or its operating units to Contractor, or is created, received, maintained or transmitted by Contractor on Hospital's behalf, shall be subject to the Agreement and this Addendum.

(b) Contractor shall not Use or Disclose Protected Health Information in any form, including electronic form ("**PHI**"), other than as permitted or required by this Addendum or required by law.

(c) Contractor shall not permit Unauthorized or Unlawful Access to PHI.

(d) Except as otherwise limited in this Addendum, Contractor may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Hospital as specified in the Agreement or for Contractor's internal operational purposes, provided that such Use or Disclosure would not violate the HIPAA Regulations or California law if done by Hospital.

(e) The Contractor shall not further Disclose any PHI (including to subcontractors) received from the Hospital or maintained by the Contractor, unless permitted by this Addendum and, in such cases, only if such Disclosure is required or permitted under California law.

(f) The Contractor shall not Disclose PHI to a health plan for payment or health care operations purposes if the Individual has requested this special restriction and has paid out-of-pocket in full for the health care item or service to which the PHI solely relates.

(g) Except as otherwise provided for in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. (See 45 C.F.R. §164.504(e)(4)(i)).

(h) Except as otherwise provided for in this Agreement, Business Associate may Disclose Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that Disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is Disclosed that it will remain confidential and Used or further Disclosed only as Required By Law or for the purpose for which it was Disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been Breached. (See 45 C.F.R. §164.504(e)(4)(ii)).

(i) To the extent that Contractor is to carry out one or more of Hospital's obligations under Subpart E of 45 CFR Part 164, Contractor shall comply with the requirements of Subpart E that apply to Hospital in the performance of the obligations.

4. Disclosure Accounting. In the event that Contractor makes any Disclosures of PHI that are subject to the accounting requirements of 45 CFR Section 164.528, Contractor promptly shall

report such Disclosures to Hospital in writing. Such notice shall include the name of the individual and company affiliation to whom the PHI was Disclosed and the date of the Disclosure. Contractor shall maintain a record of each such Disclosure, including the date of the Disclosure, the name and, if available, the address of the recipient of the PHI, a brief description of the PHI Disclosed and a brief description of the purpose of the Disclosure. Contractor shall maintain this record for a period of six (6) years and make such records available to Hospital upon request in an electronic format so that Hospital may meet its Disclosure accounting obligations under 45 CFR Section 164.528.

5. Access to PHI by Individuals. Contractor shall cooperate with Hospital to fulfill all requests by Individuals for access to the Individual's PHI that are approved by Hospital. Contractor shall cooperate with Hospital in all respects necessary for it to comply with 45 CFR Section 164.524. If Contractor receives a request from an Individual for access to PHI, Contractor immediately shall forward such request to Hospital, who shall be solely responsible for determining the scope of PHI and Designated Record Set with respect to each request by an individual for access to PHI. If Contractor maintains PHI in a Designated Record Set on behalf of Hospital, Contractor shall permit any Individual, upon notice by Hospital, to access and obtain copies of the individual's PHI in accordance with 45 CFR Section 164.524. Contractor shall make the PHI available in the format requested by the Individual and approved by Hospital. If Business Associate maintains the PHI in a Designated Record Set in electronic form and an Individual requests a copy of such information in electronic format, Business Associate shall provide such information in electronic format to Hospital in order for it to comply with its obligation. Contractor shall not charge Hospital or the Individual any fees for such access to PHI. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

6. Amendment of PHI. Contractor shall incorporate all amendments to PHI received from Hospital within five (5) business days of receipt. Contractor shall provide written notice to Hospital within five (5) business days of completing such amendment(s). Such notice shall confirm that Contractor has made the amendment(s) to PHI as directed by Hospital and shall contain any additional information necessary for Hospital to provide adequate notice to the Individual in accordance with 45 CFR Section 164.526. If Contractor does not hold any information as part of a Designated Record Set, this Section shall not apply to Contractor.

7. Access to Contractor's Books and Records. Contractor shall make its internal practices, books and records relating to the Use and Disclosure of PHI received from, or created or received by Contractor on behalf of Hospital, available to the Secretary of the Department of Health and Human Services ("Secretary") for purposes of determining Hospital's compliance with the HIPAA Laws. Contractor shall provide to Hospital a copy of any PHI that Contractor provides to the Secretary concurrently with providing such PHI to the Secretary. Contractor also shall make its internal practices, books and records available within five (5) business days of a request by Hospital for inspection for purposes of determining compliance with this Agreement.

8. Security Safeguards. Contractor shall implement a documented information security program that includes administrative, technical and physical safeguards designed to prevent the accidental or otherwise unauthorized Use or Disclosure of PHI. Contractor shall require any agents, affiliates, subsidiaries or subcontractors, with access to electronic PHI related to Hospital in any way, to agree in writing to the same requirements under this Section. Moreover, Contractor shall implement administrative, physical, and technical safeguards and policy, procedure, and documentation requirements consistent with the requirements of 45 CFR Sections 164.308, 164.310, 164.312, and 164.316.

9. Reporting and Mitigating. Contractor shall immediately report, but in no event later than 24 hours, any Security Incident including any Unauthorized or Unlawful Access, Use or Disclosure of PHI or Breach of Unsecured PHI not provided for or permitted by this Addendum of which the Contractor becomes aware. Moreover, in the event that Contractor becomes aware that PHI has

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been or reasonably believes has been accessed, acquired or Disclosed as a result of a "Breach," or Unauthorized or Unlawful Access as those terms are defined by the HIPAA Laws or Section 1280.15, Contractor will notify Hospital of the Breach and/or Unauthorized or Unlawful Access, Use or Disclosure, including the identification of each Individual who has been or is reasonably believed to have been affected thereby. Contractor's notification to Hospital shall be provided in accordance with HIPAA Laws and Section 1280.15 and guidance as it may be provided by the Secretary and the California Office of Health Information Integrity. Contractor shall use its best efforts to mitigate the deleterious effects of any Unlawful Access, Use or Disclosure of PHI not authorized by this Addendum or any Security Incident.

10. Term and Termination.

(a) The Term of this Addendum shall be effective as of the Execution Date and shall terminate when all of the PHI provided by Hospital to Contractor, or created or received by Contractor on behalf of Hospital, is destroyed or returned to Hospital, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 11 below.

(b) If Hospital becomes aware of any material breach of this Addendum by Contractor, Hospital shall provide Contractor with written notice of such breach and such breach shall be cured by Contractor within thirty (30) business days of such notice. If such breach is not cured with such time period, Hospital shall immediately terminate this Addendum.

(c) If Contractor becomes aware of any material breach of this Addendum by Hospital, Contractor shall provide Hospital with written notice of such breach and such breach shall be cured by Hospital within thirty (30) business days of such notice. If such breach is not cured with such time period, Contractor shall immediately terminate this Addendum.

(d) Contractor acknowledges and agrees that Hospital may be required by HIPAA Laws to report a Breach to the Secretary of the U.S. Department of Health and Human Services and Unauthorized or Unlawful Access, Use or Disclosure of PHI to the State.

(e) The Agreement shall automatically terminate upon termination of this Addendum for any reason whatsoever.

11. Effect of Termination.

(a) Upon termination or expiration of this Addendum, Hospital shall direct Contractor to either return or destroy all PHI that Contractor obtained, created or maintained pursuant to the Agreement on behalf of Hospital. If Hospital determines at that time that the return or destruction of PHI is not feasible, Contractor shall extend the protections provided under this Addendum to such PHI, and limit further Use or Disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible.

(b) Upon termination or expiration of this Addendum, Contractor shall recover all PHI that is in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors. If Contractor believes at that time that it is infeasible for the Contractor to recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors, Contractor shall provide written notice to Hospital regarding the nature of the unfeasibility. Upon a determination by Hospital that such recovery is infeasible, Contractor shall require that its agents, affiliates, subsidiaries and subcontractors agree to the extension of all protections, limitations and restrictions required of Contractor hereunder. If Hospital determines that it is feasible to make such recovery, Contractor

shall recover all PHI in the possession of Contractor's agents, affiliates, subsidiaries or subcontractors.

(c) If Contractor or Contractor's agents, affiliates, subsidiaries or subcontractors retain any PHI pursuant to this Section 11, the terms of this Addendum shall continue to apply to the PHI retained by Contractor or any of Contractor's agents, affiliates, subsidiaries or subcontractors, even after termination of the Agreement.

12. Prohibition of Sale of PHI. Contractor may not directly or indirectly receive remuneration in exchange for any PHI without a valid Authorization specifically indicating that the PHI may be sold to the entity receiving the PHI unless the sale is otherwise authorized by the HIPAA Laws.

13. Indemnification. Each party, to the extent allowable under the California Tort Claims Act, shall indemnify, defend and hold harmless the other party and its agents, employees, contractors, officers and directors against: (i) any and all liability arising out of such party's failure to comply with the terms of this Addendum, and any injury, loss, fines, claims, or damages arising from the negligent operations, acts, or omissions of such party or its employees relating to or arising out of this Addendum; and (ii) any and all costs and expenses, including reasonable legal expenses, incurred by or on behalf of the other party in connection with the defense of such claims.

14. Contractor's Compliance with HIPAA. Hospital makes no warranty or representation that compliance by Contractor with this Addendum, the HIPAA Laws or California law will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized Use or Disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of PHI.

15. Continuing Agreement. Except as expressly modified by this Addendum, the Agreement shall continue in full force and effect. In the event of any conflict between any provision of this Addendum and any provision of the Agreement, the provision of this Addendum shall control.

16. Assignment; Binding Effect. This Addendum shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives, successors and assigns. Unless otherwise provided in the Agreement, Contractor may not assign the rights or obligations under the Agreement without the express written consent of Hospital; however, Hospital may assign its rights and obligations under this Agreement to any successor or affiliated entity without the consent of Contractor.

17. Affiliates, Agents, Subsidiaries and Subcontractors. Contractor shall require any agents and subcontractors which creates, receives, maintains or transmits PHI related to Hospital on its behalf, to agree in writing to the same Use and Disclosure restrictions and conditions imposed on Contractor by this Addendum including the requirement that such agents and subcontractors implement reasonable and appropriate administrative, physical and technical safeguards to protect such PHI. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract to such agents and subcontractors including the requirement to report Security Incidents, Breaches and Unauthorized or Unlawful Access, Use and Disclosures to Business Associate. Unless the Agreement permits Contractor to subcontract its services, Contractor shall not subcontract any of its services under the Agreement without first obtaining Hospital's prior written consent.

18. Compliance with Laws. The parties shall comply with all applicable laws, ordinances, codes and regulations of federal, state and local governments, applicable to the performance of the Agreement and this Addendum.

19. Governing Law. Unless provided otherwise in the Agreement, this Addendum shall be construed in accordance with and governed by the laws of the State of California, except the conflicts of laws provisions which would require the application of the laws of any other jurisdiction.

20. Headings. The headings in this Addendum are intended solely for convenience of reference and shall be given no effect in the construction or interpretation of this Agreement.

21. No Third-party Beneficiary Rights. Unless provided otherwise in the Agreement, the parties do not intend to confer and this Addendum shall not be construed to confer any rights or benefits to any person, firm, physician, corporation or entity other than the parties.

22. Data Ownership. Contractor acknowledges and agrees that all PHI that Contractor obtains, creates or maintains pursuant to the Agreement, on behalf of Hospital or for Contractor's internal use, is the property of Hospital and Contractor has no ownership rights with respect thereto.

23. Severability. If any provision of this Addendum is determined to be illegal or unenforceable, that provision shall be severed from this Addendum and/or the Agreement, as applicable, and such severance shall have no effect upon the enforceability of the remainder of the Agreement.

24. Counterparts. This Addendum may be executed in one or more counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

25. Data Use Application. If Contractor requests a "Designated Data Set" from Hospital, Contractor must complete a Data Use Application (Instructions and Application attached to this Addendum) and submit a completed Data Use Application with this signed Addendum. The Data Use Application may be modified or amended by mutual agreement of the parties at any time without amending the Agreement or this Addendum.

IN WITNESS WHEREOF, the parties have executed this Addendum as of the Execution Date.

HOSPITAL
Tri-City Healthcare District, a health care district organized under the Local Health Care district Law of the State of California

By: _____
Chief Executive Officer

CONTRACTOR

_____

_____

_____

_____

Signature: _____

Print Name: _____

Title: _____

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

Instructions – Data Use Application
Tri-City Healthcare District ("Hospital")

Hospital may Disclose a Designated Data Set of Protected Health Information (PHI) according to a Business Associate Agreement, if Hospital obtains satisfactory assurance that the recipient of the PHI will Use or Disclose the information only for limited purposes.

Please complete the Data Use Application, explaining your receipt and use of Hospital PHI, by answering the following questions:

- State the purpose of the information and how the Designated Data Set of PHI will be used to accomplish that purpose.
- Provide the specific purpose for the Use and Disclosure of this data.
- Identify who can Use and receive the data.
- Provide an adequate assurance of safeguards that prevent unapproved Use or Disclosure.
- Identify your plan (how and when) to destroy the Designated Data Set of PHI.

Revised: 10/19

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE ~~Policy Manual~~
COMPLIANCE

ISSUE DATE:

SUBJECT: **~~Controls and Monitoring of Payments to Physicians or Other Referral Sources~~ Processing of Payments to Physicians and Referral Source Vendors**

REVISION DATE~~(S)~~: 09/16

POLICY NUMBER: 8750-576

Department Approval ~~Date(s)~~:	**~~06/16~~12/22**
Administrative Policies and Procedures Approval ~~Date(s)~~:	**~~06/16~~01/23**
Medical Executive Committee Approval ~~Date(s)~~:	**~~07/16~~ n/a**
Organizational Compliance Committee Approval ~~Date(s)~~:	**~~08/16~~03/24**
Administration Approval:	**03/24**
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	**~~09/16~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**09/16**

A. **PURPOSE:**

1. **To identify and establish a procedure for the processing of payments to physicians and referral source vendors.** ~~To establish controls and routine monitoring of payments made to physicians and other actual or potential referral sources ("Referral Sources") through the vendor payment system. This policy does not apply to payments made to employed physicians or other employed referral sources~~.

B. **GENERAL POLICIES:**

1. Prior to issuing a payment to a new vendor or other third–party payee (a "Vendor"), Tri-City Healthcare District's (TCHD's) Chief Financial Officer (CFO), Chief ~~Operations~~ **Medical** Officer (CM~~O~~O), and Chief Compliance **&** **Privacy** Officer (CC**P**O) shall identify whether the Vendor is a Referral Source. Accounts Payable shall establish a written procedure for review and approval of all payments including Referral Source payments to ensure that payments made to Referral Sources are consistent with all laws, regulations and District policies.

C. **DEFINITION(S):**

1. Referral Source - **A**any individual or entity in a position to make or influence referrals to, or otherwise generate business for TCHD. Examples include physicians, medical device companies, pharmaceutical companies, ambulance companies, emergency services providers, etc.

D. **SCOPE OF POLICY:**

1. This policy applies to:
   a. TCHD and its wholly-owned subsidiaries and affiliates; **and**
   b. Any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%~~; and~~.

E. **PROCEDURE:**

1. New Vendors:

a. New Vendors shall complete an Accounts Payable Vendor Addition Form, which, among other information, identifies whether the vendor is a Referral Source. ~~The~~TCHD's CFO, CM~~O~~O, and CC**P**O, or their designees, are required to approve and sign all Vendor Addition Forms to ensure, among other things, that all Vendors are appropriately categorized as Referral Sources or Non-Referral Sources. Accounts Payable requires the completion and approval of the Vendor Addition Form prior to adding a new Vendor to the Accounts Payable system or releasing any payment to a Vendor.

2. Auditing ~~and Monitoring:~~
   a. The CF~~C~~O, or designee, shall audit adherence to this policy in its routine audits.
3. Responsible Person
   a. The TCHD CFO is responsible for the establishment and maintenance of controls for the processing of payments as outlined in this policy even if the CFO has delegated the review requirements of this policy to another member of the Finance staff.
4. Enforcement
   a. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **RELATED DOCUMENT(S):**
1. Referral Source Payment Type Form

REFERRAL SOURCE PAYMENT TYPE FORM

- ☐ Billing Services for Physician
- ☐ Certificate of Insurance Provided
- ☐ CME (for physician)
- ☐ Compliance Training (for physician)
- ☐ Computer Equipment Agreement
- ☐ Continuing Education Presentation (by physician)
- ☐ Cost of Insurance
- ☐ EHR and ERx Technology Subsidy
- ☐ Entertainment (event tickets, golf, etc.)
- ☐ Equipment Lease Agreements
- ☐ Free Meals at Hospital
- ☐ Free Parking at Hospital
- ☐ Gift Certificates
- ☐ Gifts (non-monetary compensation)
- ☐ Hospital Based Service Agreements
- ☐ Joint Venture Agreements
- ☐ Medical Office Space Provided
- ☐ Medical Staff Leadership Stipend
- ☐ Medical Staff Appreciation Dinner
- ☐ Medical Supplies Provided
- ☐ Payment for Peer Review Services
- ☐ Physician Consulting Agreements
- ☐ Physician Lease Agreements
- ☐ Physician Medical Director Arrangements
- ☐ Physician Marketing Assistance
- ☐ Physician On-Call Agreements
- ☐ Physician Recruitment Assistance
- ☐ Physician Services Agreements
- ☐ Physician Serving on TCHD Board
- ☐ Professional Courtesy Discount
- ☐ Reimbursement of Expenses
- ☐ Room Rental Fee
- ☐ Smart Devices
- ☐ Soliciting Charitable Donation From Physician
- ☐ Space Lease Agreement
- ☐ Staffing Support for Physician Practice
- ☐ Uninsured Care Arrangements

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE POLICY
COMPLIANCE

ISSUE DATE:	**03/03**	**SUBJECT:**	**Faxing of Protected Health Information (Medical Records)**
REVISION DATE:	**05/09, 07/14**	**POLICY NUMBER:**	**8610-522**

Administrative Content Expert~~Department Review~~ Approval: ~~11/17~~11/20
Administrative Policies & Procedures Committee Approval: ~~12/17~~11/22
Organizational Compliance Committee Approval: 03/24
Administration Approval: 03/24
Audit Compliance and Ethics~~Professional Affairs~~ Committee Approval: ~~01/18~~ n/a
Board of Directors Approval: 01/18

A. **PURPOSE:**

1. To ensure confidentiality of patient protected health information transmitted via fax machine.

B. **DEFINITIONS:**

1. **Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in electronic and/or other format that is created or received by TCHD, and**
   a. **Relates to the past, present, or future physical or mental health or condition of an individual; or**
   b. **Relates to the provision of health care to an individual; or**
   c. **Relates to the past, present, or future payment; and**
   d. **Identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.**

~~1.~~2. **Minimum Necessary: Tri-City Healthcare District (TCHD) or a business associate taking reasonable efforts to use, disclose, and request only the minimum amount of PHI needed to accomplish the purpose.**

~~B.~~C. **POLICY:**

1. It is the policy of ~~Tri-City Healthcare District (~~TCHD~~)~~ to limit the faxing of ~~patient information~~**PHI** and outline standard procedures to ensure that patient confidentiality is maintained.
2. Faxing of ~~patient information~~**PHI** is to be limited to emergency situations (patients currently being seen in a physician's office or another health care facility), **minimum necessary,** ~~and~~ those situations dealing with direct patient care (i.e. discharge planning, medical consultation, patient transfer, etc.)
3. The faxing of ~~information~~ **PHI** for **or to** a patient who is not currently an inpatient is to be handled by the Medical Records/Health Information Department.
4. ~~Care is to be taken to limit information being faxed is the minimum necessary to meet the needs of the recipient.~~
5. ~~Departments which utilize the Cerner system to fax results/reports to physician offices are to ensure that test documents (non-patient related) have been transmitted and received without error prior to initiation of automated transmission of patient documents.~~
   a. ~~Annual review of the automated system fax number database is to be completed by the Information Technology (IT) Department with support by Health Information Management (HIM) as needed.~~
   b. ~~The IT Department to maintain signed agreement from the physician's office reflecting steps to be taken when a fax number changes or is no longer valid.~~

~~6.~~**4.** Departments ~~which~~ **that utilize the Cerner system to fax results/reports to physician offices or** have fax machines preprogrammed to transmit ~~information~~ **PHI** to a designated office/unit are to ensure that test documents (non-patient related) have been transmitted and received without error prior to implementation of faxing documents without an accompanying transmittal sheet. (**e.g**~~.~~**i.e**. ABG results to staff physician offices, **s**~~S~~urgery **s**~~S~~cheduling to **p**~~P~~re-**o**~~O~~perative teaching, etc.)

a. Annual review of the automated system fax number database is to be **completed by the department and** documented.

~~a.~~**b. Annual review of the Cerner automated system fax number database is to be completed by the Information Technology (IT) Department with support by Health Information Management (HIM), as needed.**

~~b. Department is to maintain signed agreements from the physician's office reflecting steps to be taken when a fax number changes or is no longer valid.~~

~~7.~~**5.** A transmittal form is to be completed on all manual fax transmittals. The transmittal form must include at minimum the following:

a. Patient Name
b. Medical Record number of the patient
c. Date of Service
d. Name of Person to whom information is being faxed
e. Date and time of fax transmission
f. Specification of record component being faxed
g. Name of person faxing the information
h. The protection clauses relating to further disclosure. Departments may create transmittal forms pertinent to their unit, which cover these required elements.

~~8. Patient information is not faxed directly to any patient.~~

~~a.~~**6.** The fax machine is to be set to generate a confirmation sheet that will be scanned to Cerner (Disclosure) upon completion of the transmission. This confirmation sheet is to be filed and maintained as part of the patient's permanent medical record under the face sheet. In cases where the confirmation sheet does not reflect the transmittal sheet information, confirmation of the transmission is to be recorded on the transmittal form.

~~b.~~**a.** If a confirmation sheet is not generated by the fax machine the person initiating the fax transmission is to contact the receiving party when possible to confirm receipt of the patient's information. Verbal confirmation of receipt of the information is to be recorded on the transmittal sheet, which is then to be filed on and maintained as part of the patient's permanent medical record.

~~c.~~**b.** If a transmittal and/or confirmation sheet is not utilized when faxing it is required that the following information be documented in the Progress Notes.

i. To whom the information was faxed.
ii. Identification of the specific information that was faxed.
iii. Written statement, which reflects receipt of the fax by the party to whom it was sent.

~~9.~~**7.** Every effort is to be taken to assure that information reaches its destination and is kept confidential in accordance with Administrative Policy: Confidentiality 455.

a. Should an employee/physician be informed that the intended party did not receive the faxed information, it is required that this be documented on the "transmittal" form and a ~~Quality Review Report (QRR)~~**the incident** is to be ~~submitted~~ **reported** to the **Chief Compliance and** Privacy Officer~~.~~.

~~a.~~ **~~8. PHI is not to be faxed directly to any patient.~~**

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

1. Medical Record Department Fax Transmittal Sheet 8700-1027

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

1. Administrative Policy: Confidentiality 455

Tri-City Medical Center
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: 04/18

SUBJECT: Hospital Issued Notice of Noncoverage of Medicare-Covered Services (HINN)

REVISION DATE:

POLICY NUMBER: 8610-398

Department Review:	~~10/17~~04/23
Administrative Policies & procedures Committee Approval:	~~10/17~~04/23
Organizational Compliance Committee Approval:	~~02/18~~03/24
Administration Approval:	03/24
Audit, Compliance and Ethics Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

A. **PURPOSE:**

1. To explain the CMS ruling regarding the Notice of Medicare Provider Non-Coverage for the Medicare beneficiaries.

B. **POLICY:**

1. It is the policy of the hospital to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with Hospital Issued Notice of Noncoverage of Medicare-covered services (HINN).

C. **PROCEDURE:**

1. Hospitals give HINNs to beneficiaries when issues of noncoverage arise for hospital-level inpatient care. The HINN may be given prior to admission, at admission, or at any point during the inpatient stay. It may be issued by hospital staff or utilization review committees based on Medicare instructions, including: coverage guidelines, notices, bulletins, or other written guides or directives from intermediaries or Quality Improvement Organizations (QIOs). After the hospital issues a notice of noncoverage, the beneficiary or **their**~~his/her~~ representative is considered to have knowledge that services are not covered and is liable for customary charges. The hospital is not required to issue a HINN when it does not plan to bill the beneficiary or ~~his/her~~**their** representative. Potential liability may arise when the hospital determines that certain inpatient services are never covered by Medicare. It may also arise when an inpatient stay, either in whole or in part, or a specific, severable service during an otherwise covered stay: Is not considered reasonable and necessary, Can be provided safely in another setting is custodial in nature.
2. Types of HINNS:
   a. HINN 1 – Preadmission/Admission HINN: the hospital may issue a preadmission/admission HINN when the hospital has determined at the time of preadmission or admission that a beneficiary's stay will be a non-covered stay.
      i. Preadmission HINN -- The beneficiary or ~~his/her~~**their** representative is liable for customary charges for all services furnished if he/she enters the hospital after receipt of a preadmission HINN.
      ii. Admission HINN -- Determine liability as follows:
         1) *HINN Issued on the Day of Admission* – The beneficiary or ~~his/her~~**their** representative is liable for customary charges for all services furnished

after the admission HINN is received. However, to hold a beneficiary or ~~his/her~~**their** representative liable for charges on the day of admission, the hospital must issue the admission HINN no later than 3:00 p.m. on the day of admission. If the hospital does not meet these requirements, the beneficiary or ~~his/her~~**their** representative is protected from liability until the day following receipt of the admission HINN (e.g., a HINN issued for an admission after 3:00 p.m. or a late evening admission).

2) *HINN Issued After the Day of Admission* – The beneficiary or ~~his/her~~**their** representative is liable for customary charges for all services furnished beginning the day following the date of receipt of the admission HINN.

a) Timing for Preadmission/Admission HINN Request & Review- When a beneficiary or ~~his/her~~**their** representative requests review of a preadmission or an admission HINN, the QIO will review any records pertaining to health care services furnished. This includes records pertaining to any inpatient hospital services provided or proposed to be provided to the Medicare beneficiary whether or not, in the hospital's view, the services are covered.

i) Immediate Review – If the beneficiary or ~~his/her~~**their** representative disagrees with the hospital preadmission notice, he/she may request your review, by telephone or in writing, within 3 calendar days of receipt of the HINN. If admitted, the beneficiary or ~~his/her~~**their** representative may request your review at any point during the stay. In either situation, the QIO will review the case within 2 working days following the beneficiary's or ~~his/her~~**their** representative's request, and issue either a denial notice or a notice explaining that the care would be, or is, covered.

ii) Review after Discharge or When Beneficiary Was Not Admitted to Hospital – The beneficiary or ~~his/her~~**their** representative may request review within 30 calendar days after receipt of the notice. The QIO completes this review within the timeframe specified for any retrospective review – 30 calendar days. Once the QIO review is completed, either a denial notice or a notice explaining that the care would be, or is, covered is issued. In all cases of appropriately requested reviews, QIOs will formally determine if the hospital notification was valid, if the hospital's findings were valid, and if beneficiaries will be liable should they remain in the hospital. If the right to reconsideration is exercised, final notification does not occur until the reconsideration is complete.

b. HINN 10 – Hospital Requested Review (HRR): When a hospital determines that a beneficiary no longer requires an acute level of inpatient care, but the attending physician does not agree, the hospital may request a QIO review of the medical record—known as a hospital requested review (HRR). Hospitals must notify the beneficiary that the review has been requested. The QIO review of the hospital's determination considers whether or not continued inpatient care is needed (42 CFR 405.1208(b)(1), effective July 1, 2005).

c. HINN 11 is used for non-covered items or services provided during an otherwise covered inpatient stay. The notice may be used to hold beneficiaries liable for certain non-covered services. The item or service at issue must be a diagnostic or therapeutic service excluded from Medicare coverage as medically unnecessary and the beneficiary must require continued inpatient hospital care.

d. HINN 12 is a liability notice to be used in association with the Hospital Discharge Appeal Notices to inform beneficiaries of their potential liability for a non-covered continued stay after the appeal is completed or the time frame for requesting an expedited review is past. The compliance with this notice does not fall under the review authority of the QIO. (Refer to IMFM Policy)
   i. HINN 12 is designed to inform patients who remain in the hospital without seeking timely review of their liability for services provided after the date of the proposed discharge. Timely review (by midnight of the date of the proposed discharge) would limit the patient's liability to applicable deductibles and coinsurance until noon of the day after the discharge date on which the QIO notifies the patient of its agreement with the hospital. Failure to seek timely review appears to subject patients who remain in the hospital to liability for all Part A inpatient services provided after the date of the proposed discharge, unless the QIO determines otherwise.

e. Beneficiary Payment Responsibility
   i. HINNs do not address every aspect of beneficiary responsibility for payment. Beneficiaries remain liable for applicable deductible and coinsurance amounts, and for charges for convenience items or services never covered by Medicare, even in periods where covered care is also delivered. Hospitals are not required to issue HINNs when the beneficiary will not be billed/liable.

D. RELATED DOCUMENT(S):

1. Administrative Policy: Important Message From Medicare and Notification of Hospital Discharge Appeal Rights 392

E. REFERENCE(S):

1. Center for Medicare & Medicaid Services (2017, April 13). Beneficiary Notices Initiative (BNI). Retrieved from https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni/
2. Center for Medicare & Medicaid Services. Details for Title 100-04: Medicare Claims Processing Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending
3. Center for Medicare & Medicaid Services. Details for Title 100-10: Quality Improvement Organization Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019035.html?DLPage=2&DLSort=0&DLSortDir=ascending
4. CMS Manual System (2005, October 14). Correction to Change Request 3949, Section 50.3.3 in IOM to Add 23x Type of Bill. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R712CP.pdf
5. Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary, Title 42 CFR 411.404 (1989).
6. Preadmission/Admission HINN. Medicare Claims Processing Manual, Transmittal 982

Tri-City Health Care District
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: 03/10

SUBJECT: **Important Message from Medicare and Notification of Hospital Discharge Appeal Rights**

REVISION DATE: 03/10

POLICY NUMBER: 8610-392

Department Review:	~~09/17~~04/23
Administrative Policies & Procedures Committee Approval:	~~09/17~~04/23
Organizational Compliance Committee Approval:	~~02/18~~03/24
Administration Approval:	03/24
Audit, Compliance and Ethics Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

A. **PURPOSE:**

1. To comply with the Centers for Medicare and Medicaid Services (CMS) regulatory requirements that hospitals notify Medicare or Medicare Advantage plan beneficiaries who are hospital inpatients about their hospital discharge rights.

B. **DEFINITION(S):**

1. Important Message from Medicare (IMFM) CMS-R-193: A hospital inpatient admission notice given to all beneficiaries with Medicare, Medicare and Medicaid (dual-eligible), Medicare and another insurance program, Medicare as a secondary payer.
2. Quality Improvement Organization (QIO):
   a. QIO enacted by Federal statute "to improve the efficiency, effectiveness, economy and quality or services delivered to Medicare Beneficiaries".
3. Representative:
   a. A representative is defined broadly to include individuals authorized to act on behalf of the beneficiary; someone acting responsibly on behalf of an incapacitated or incompetent beneficiary; or someone requested by the beneficiary to act as his or her agent.
4. Detailed Notice of Discharge (CMS-10066):
   a. Hospitals must deliver the Important Message from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice.

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) must issue the IMFM within two (2) days of admission and must obtain the signature of the beneficiary or his/her representative. TCHD must deliver a copy of the signed notice to each beneficiary not more than two (2) days before the day of discharge. Follow-up notice is not required if delivery of the initial IMFM falls within two (2) calendar days of discharge, if the beneficiary is being transferred from one inpatient hospital setting to another inpatient hospital setting, or when a beneficiary exhausts Part A hospital days. TCHD must retain a copy of the signed notice.

D. **PROCEDURE:**

1. Initial Notice:

a. TCHD personnel must provide the IMFM at or near admission but no later than two (2) calendar days from the day of admission or at preadmission, but not more than seven (7) calendar days before admission, and obtain the signature and signature date of the patient or representative to indicate receipt of notice.
b. The original is given to the patient with a copy retained by the hospital.

2. Follow-Up Notice:
   a. The follow-up IMFM must also be provided to the patient as soon as possible prior to discharge, but no more than two (2) days before.
      i. When a discharge seems likely in one (1) to two (2) days, the follow-up notice should be given to the patient, so the patient has ample time to review and act on it.
      ii. If the follow up notice is delivered on the day of discharge, the patient must be given at least four (4) hours prior to discharge to consider their rights.
   b. TCHD must document delivery of the notice in order to demonstrate compliance with this requirement.
   c. If TCHD delivers the follow-up notice, and the beneficiary status subsequently changes, so that the discharge is beyond the two (2) day timeframe, TCHD must deliver another copy of the signed notice again within two (2) calendar days of the new planned discharge date.
3. Beneficiary Refusal to Sign:
   a. If the beneficiary refuses to sign the notice, the hospital should note the refusal and date of refusal on the form and this will be considered the date of notice.
4. Medical Record Documentation:
   a. TCHD should place a copy of the initial notice in the patient's medical record.
   b. TCHD must document timely delivery of the follow-up copy of the IMFM in the patient records, when applicable.
   c. TCHD should also document any attempted contact with beneficiary representatives, including telephone calls, messages and subsequent certified mail.
5. Copies:
   a. IMFM form (Initial Notice):
      i. 2 Copies:
         1. Original notice for patient is in the medical record
         2. Patient's copy
   b. IMFM form (Follow up Notice):
      i. 2 copies:
         1. Original notice for patient is in the medical record
         2. Patient's copy
   c. Detailed Notice:
      i. 2 copies:
         1. Original notice for hospital
         2. Patient's copy
      ii. Additional copies may be needed if the patient requests a review, as the QIO will require a copy.
   d. Prior to the patient signing and dating an IMFM and/or Detailed Notice of Discharge, TCHD must ensure the patient comprehends the contents of the notice.
   e. Notices should not be delivered in an emergency medical situation.
6. Expedited Reviews:
   a. A patient has a right to request a review of the discharge decision, by asking for an expedited review by the QIO when the hospital, with physician/Allied Health Professional (AHP) concurrence, determines that inpatient care is no longer necessary. The process is as follows:
      i. The patient submits a request for review to the QIO no later than midnight of the day of discharge that has been ordered by the physician/AHP.

ii. The request may be in writing or by telephone and must be before the patient leaves the hospital.
    1. If the request is not in this timeframe, and the patient remains in the hospital, he or she may request a review at any time, but will be held responsible for the charges incurred after the date of discharge ordered.
iii. When the patient requests a review prior to midnight the day of discharge, the patient is not financially responsible for inpatient hospital services (except coinsurance and deductibles) furnished before noon the day after the patient receives notification of the determination from the QIO.
iv. If the QIO does not agree with the patient, the liability for continued services begins at noon of the day after the QIO notifies the patient.
v. If the QIO does agree with the patient, the patient is not financially responsible for continued care, until the hospital once again determines that the patient no longer requires inpatient care, secures the concurrence of the physician responsible for the patient or the QIO and notifies the patient with a follow-up copy of the IMFM.

~~E. **RELATED DOCUMENT(S):**~~
~~1. CMS-R-193 An Important Message From Medicare About Your Rights Sample~~
~~2. CMS-10066 Detailed Notice of Discharge Sample~~

~~F.~~**E. REFERENCE(S):**
1. CMS Transmittal 1257, May 2007, CR 5622

~~CMS-R-193 An Important Message From Medicare About Your Rights Sample~~

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____.

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative	Date/Time

Form CMS-R-193 (Exp. 03/31/2020)

Steps To Appeal Your Discharge

- **Step 1**: You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO:

    Name of QIO (in bold)

    Telephone Number of QIO
  - You can file a request for an appeal any day of the week. **Once you speak to someone or leave a message, your appeal has begun.**
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name	Provider ID Number

- **Step 2**: You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3**: The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4**: The QIO will review your medical records and other important information about your case.
- **Step 5**: The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.
CMS does not discriminate in its programs and activities. To request this publication in an alternate format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov .

Additional Information:

CMS-10066 Detailed Notice of Discharge Sample

Patient Name:
Patient ID Number:
Physician:

OMB Approval No. 0938-1019
Date Issued:

{Insert Hospital or Plan Logo here}

Detailed Notice Of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  _____ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  _____ Medicare Managed Care policies, if applicable: _____ _____ {insert specific managed care policies}

  _____ Other _____ {insert other applicable policies}

- Specific information about your current medical condition:

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call _____{insert hospital and/or plan telephone number}.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 12/02 **SUBJECT: Notice of Privacy Practices**

REVISION DATE(S): 09/05, 01/09, 06/15 **POLICY NUMBER: 8610-518**

Administrative Compliance Content Expert Approval:	**~~08/18~~01/23**
Administrative Policies & Procedures Committee Approval:	**~~12/18~~03/23**
Organizational Compliance Committee Approval:	**03/24**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**03/24**
Audit, Compliance & Ethics Committee Approval:	**~~02/19~~ n/a**
Board of Directors Approval:	**02/19**

A. **PURPOSE:**

1. To establish a policy for documenting the acknowledgment of the patient's receipt of the Notice of Privacy Practices in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA) which gives patients the right to know the Uses and Disclosure of their protected health information.

B. **DEFINITIONS:**

1. Disclosure: **T**~~t~~he release, transfer, provision of, access to or divulging of PHI outside Tri-City Healthcare District (TCHD).
2. Notice of Privacy Practices (NPP): TCHD's written notice to individuals of Uses and Disclosures of PHI as required by 45 Code of Federal Regulations (CFR) Section 164.520.
3. Protected Health Information (PHI): **I**~~i~~ndividually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD **and**~~AND~~
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment, **and**~~AND~~
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
4. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD
5. Workforce Member: ~~means~~ employees, Medical Staff and Allied Health Professionals, volunteers, trainees**, Business Visitors, Covered Contractors** and other persons whose conduct in the performance of work for TCHD is under the control of TCHD whether or not they are paid by TCHD.

C. **POLICY:**

1. In accordance with HIPAA, all patients have a right to adequate notice of the Uses and Disclosures of PHI that may be made by TCHD.
2. TCHD communicates Uses and Disclosures of PHI that may be made by TCHD in its Notice of Privacy Practices.
3. TCHD must make the Notice of Privacy Practices available to patients as described in this Policy.
4. As provided under HIPAA, TCHD is required to abide by the terms of the Notice that is currently in effect.

D. **PROCEDURE:**

1. TCHD must make the NPP available as follows:
   a. TCHD must make the NPP available on request to any patient.
   b. Where TCHD has a direct treatment relationship with an individual, it must also provide the NPP no later than the date of the first service delivery except for emergency treatment situations where the NPP can be provided as soon as practicable after the emergency treatment situation.
2. The NPP will also be posted on the TCHD Website and will be made available at all registration sites, and the Medical Records/Health Information Management office. Registration or other points of entry to TCHD including but not limited to those listed below will be the primary sites where this process takes place. Since a patient's condition or location may preclude documenting the acknowledgement at the time of registration or entry into TCHD, all TCHD staff share the responsibility of ensuring acknowledgement of the Notice.
   a. Homecare
   b. Outpatient Rehabilitation
   c. Outpatient Behavioral Health
   d. Obstetrics
3. NPP Exception: Lab specimens are an exception to this Policy. No Notice of Privacy Practices will be offered because specimens are covered under the Indirect Treatment Relationship provision.
4. Amendment of NPP: If the NPP is revised, TCHD shall make the revised NPP available on request on or after the effective date of the revision.
5. TCHD must document the patient's acknowledgment of receipt or good faith efforts to obtain the acknowledgement.
   a. The Condition of Admissions document includes a section reflecting patient's acknowledgement that a NPP has been offered and online access is available via TCHD website is communicated. Patients will be asked to **sign**~~initial~~ the Conditions of Admission acknowledgement referencing the most current version of the NPP, even if they have signed an acknowledgement of a previous version.
   b. If the patient receives the NPP and the acknowledgement section of the Conditions of Admissions is not **signed**~~initialed~~, TCHD personnel must document good faith efforts to obtain it and the reason for lack of signature.
   c. The Notice of Privacy Practice acknowledgment need only be documented once, unless there is a significant content change in the Notice. Each new version of the Notice requires the patient to **sign**~~initial~~ a new acknowledgement.
6. TCHD has the right to change the NPP at any time including for the purpose of amending it to conform to changes in the law. The effective date of the NPP is located on the first page of the NPP.
7. Retention of NPP:
   a. The completed Conditions of Admission acknowledgement will be kept in the patient's medical record for the encounter for which it was signed.
   b. TCHD will retain the required documentation related to the NPP for at least 6 years from the date of creation or the date when it was last in effect whichever is later.
8. Training on NPP: All employees of TCHD will be trained on and knowledgeable of the contents of the Notice because it documents how TCHD will handle Uses and Disclosures of its patients' protected health information.

E. **RELATED DOCUMENT(S):**
1. Notice of Privacy Practices

F. **REFERENCE(S):**
1. 45 Code of Federal regulations (CFR) section 164.520

NOTICE OF PRIVACY PRACTICES
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056
[Effective Date 01~~12~~/30~~1~~/2023~~0~~]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer at (760) 940-**3117**~~5381~~

OUR PLEDGE TO PROTECT YOUR PRIVACY

Tri-City Healthcare District is committed to protecting the privacy of health information we create or receive about you. Health information that identifies you ("protected health information", or "health information") includes your medical record and other information relating to your care or payment for care.

Tri-City Healthcare District (the "District" for purposes of this Notice) includes the following entities: Tri-City Medical Center and outpatient clinics, Tri-City Wellness Center outpatient clinics, Tri-City Primary Care, Orthopedic Specialists of North County and other Affiliates.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the District's practices and that of:

Any health care professional authorized to update or create health information about you.
All departments and units of the District, including affiliated physician clinics.
Any member of a volunteer group we allow to help you while you are in one of the District's facilities.
All employees, staff and other District personnel.
All affiliated entities, sites, and locations.

All these entities, sites and locations follow the terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this Notice.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive at the District. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by the District, whether made by District personnel or your personal physician. Your personal physician may have different policies or Notices regarding the physician's use and disclosure of your medical information created in the physician's office or clinic.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request requires a written authorization by you.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to physicians, nurses, technicians, health care students, or other District personnel who are involved in taking care of you.

For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the physician may tell the dietician if you have diabetes so that we can arrange for appropriate meals.

Different departments within the District's facilities may also share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside the District who may be involved in your medical care after you leave the District's facilities, such as skilled nursing facilities, home health agencies, and physicians or other practitioners.

For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the District may be billed to and payment may be collected from you, an insurance company or a third party.

For example, we may need to give information about surgery you receive at the District to your health plan so it will pay us or reimburse you for the surgery.

We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment to practitioners outside the District who are involved in your care, to assist them in obtaining payment for services they provide to you. However, we cannot disclose information to your health plan for payment purposes if you ask us not to, and you pay for the services yourself.

FOR HEALTHCARE OPERATIONS

We may use and disclose medical information about you for health care operations. These use and disclosures are necessary to run the District and make sure that all our patients receive quality care.

For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.

We may also combine medical information about many hospital patients to decide what additional services the District should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to physicians, nurses, technicians, medical students, and other District personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

FUNDRASING ACTIVITIES

We may use information about you or disclose such information to a foundation related to the District, to contact you in an effort to raise money for the District and its operations. You have the right to opt out of receiving fundraising communications. If you receive a fundraising communication, it will tell you how to opt out.

HEALTH INFORMATION EXCHANGE

We participate in both the Commonwell and San Diego Health Connect information exchanges with other healthcare providers. This Notice is to inform our patients that our clinical team exchanges information for patient care and you can OPT OUT of the sharing of your information by communicating your choice during the Registration process or by sending a message to our Chief Compliance and Privacy Officer via our website (tricitymed.org) or submitting a written request to our Chief Compliance and Privacy Officer (4002 Vista Way, Oceanside, CA 92056).

HOSPITAL DIRECTORY

We may include certain limited information about you in the Tri-City Medical Center directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g. good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

MARKETING AND SALE

Most uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of medical information, require your authorization.

TO INDIVIDUALS INVOLVED IN YOUR CASE OR PAYMENT FOR YOUR CASE

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make healthcare decisions for you (e.g. a family member or agent under a health care power of attorney).

FOR RESEARCH

Under certain circumstances, we may use and disclose medical information about you for research purposes.

For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information.

Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the District.

AS REQUIRED BY LAW

We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

ORGAN AND TISSUE DONATION

We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

If you are a member of the Armed Forces, we may disclose medical information about you to the Department of Veterans Affairs upon your separation or discharge from military services. This disclosure is necessary for the Department of Veterans Affairs to determine if you are eligible for certain benefits.

WORKERS' COMPENSATION

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH ACTIVITIES

We may use and disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

HEALTH OVERSIGHT ACTIVITIES

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil right laws.

LAWSUIT AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may release medical information if asked to do so by law enforcement official:

- In response to court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

SECURITY CLEARANCES

We may use medical information about you to make decisions regarding your medical suitability for a security clearance or service abroad. We may also release your medical suitability determination to the officials in the U.S. Department of State who need access to that information for these purposes.

INMATES

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary

- for the institution to provide you with health care;
- to protect your health and safety or the health and safety of others; or
- for the safety and security of the correctional institution.

MULTIDISCIPLINARY PERSONNEL TEAMS

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

SPECIAL CATEGORIES OF INFORMATION

In some circumstances, your health information may be subject to restriction that may limit or preclude some uses or disclosures described in this Notice.

For example, there are special restrictions on the use or disclosure of certain categories of information — e.g. tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

SITUATIONS THAT REQUIRE US TO OBTAIN YOUR AUTHORIZATION

For uses and disclosure not described above, we must first obtain your authorization. For example, the following uses and disclosures will only be made with your authorization:

- Uses and disclosures for marketing purposes;
- Uses and disclosures that constitute the sale of Protected Health Information;
- Most uses and disclosures of psychotherapy notes; and
- Other uses and disclosures not described in this Notice.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

You have the following rights regarding medical information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but may not include some mental health information.

To inspect and obtain a paper or electronic copy of medical information that may be used to make decisions about you, you must submit your request in writing to our Director of Healthcare Information Management Services (HIMS). If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and obtain a copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

RIGHT TO REQUEST AN AMENDMENT

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the District.

To request an amendment, your request must be made in writing and submitted to our Director of HIMS. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to our Director of HIMS. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law following a breach of your unsecured protected health information.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, except to the extent that you request us to restrict disclosure to a health plan or insurer for payment or health care operations purposes if you, or someone else on your behalf (other than the health plan or insurer), has paid for the item or service out of pocket in full. Even if you request this special restriction, we can disclose the information to a health plan or insurer for purposes of treating you.

If we agree to another special restriction, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Director of HIMS. In your request, you must tell us:

- What information you want to limit
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures from your spouse

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Director of HIMS. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have a right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

You may obtain a copy of this Notice at our website: tricitymed.org

To obtain a paper copy of this Notice, contact our Registration department.

Each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

COMMENTS OR COMPLAINTS

We welcome your comments about our Notice and our privacy practices. If you believe your privacy rights have been violated, you may file a complaint with:

TRI-CITY HEALTHCARE DISTRICT
CHIEF COMPLIANCE OFFICER AND PRIVACY OFFICER
4002 VISTA WAY
OCEANSIDE, CA 92056
(760) 940-3117~~5381~~

Or with the: Secretary of the Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

Please be assured that no one will retaliate or take action against you for filing a complaint.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of care that we provided to you.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and update this Notice accordingly. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We post copies of the current Notice in the registration areas and on our internet sites. If the Notice is changed, we will post the new Notice in our registration areas and provide it to you upon request. The Notice contains the effective date on the first page, in the top right-hand corner.

To request a copy of this notice in other languages, Braille, large print, audiocassette, or on another type of digital storage device, please call or write the Chief Compliance and Privacy Officer at the number or address listed above.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 07/02 **SUBJECT: Infection Prevention Program Plan**

REVISION DATE: 04/09, 05/12, 09/15, 09/18, 05/22
09/18, 01/24

Infection Control Department Approval:	**~~05/22~~01/24**
Infection Control Committee Approval:	**~~11/22~~01/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/23~~02/24**
Administration Approval:	**~~02/23~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **PURPOSE**:
1. The purpose of the Infection Prevention (IP) Program Plan is to outline the annual infection prevention priorities of Infection Prevention and Tri-City Medical Center (TCMC). In order to achieve, an organized systematic plan is developed based upon the annual infection control risk assessment that provides the foundation for an effective infection prevention program.

B. **GOALS**:
1. Overall
   a. Reduce risk of healthcare-associated infections for all patients, employees, and visitors.
2. Targeted
   a. Healthcare-associated infection reduction – at least 30% reduction overall across the infection types that are reported to CMS (MRSA bacteremia, *C.difficile*, CLABSI; SSI Hysterectomy and Colon surgery; CAUTI). (Note: infection counts are based on CMS required reporting regulations, not necessarily all hospital-wide infections)
   b. H~~h~~and hygiene compliance program
      i. Incorporate patients and families
         1) Develop a bundle of tools for patients and family involvement
      ii. Consistently sustain ≥9~~6~~0 percent compliance across locations and job classes
         1) At least 9~~6~~0 percent of all locations and job classes must sustain 9~~6~~0 percent compliance or higher (for all locations/job classes submitting at least 40~~25~~ observations/month)
      iii. Promote engagement
         1) Develop tools for promoting involvement across all job categories
         2) develop new incentives and rewards.

C. **RISK ASSESSMENT**:
1. See Annual Facility Infection Risk Assessment
2. Patient Populations at Increased Risk of Infection
   a. All intensive care unit patients
   b. Immunosuppressed patients (e.g., absolute neutrophil count (ANC) <1000
3. Procedures/Devices that Increase Infection Risk
   a. Central venous catheters
   b. Indwelling urinary catheters
   c. Tubes, drains, other devices inserted percutaneously
   d. Intubation and prolonged ventilator support

e. Surgical procedures
f. ECMO/VAD

4. Epidemiologically Important Pathogens
   a. Legionella
   b. Aspergillus
   c. MRSA
   d. VRE
   e. *C. difficile*
   f. MDR Gram negative bacteria
   g. Carbapenem-resistant *Enterobacteriacae*
   h. *Candida auris*
5. Highly Communicable Diseases
   a. Novel Influenza virus
   b. SARS-CoV
   c. MERS
   d. Viral hemorrhagic fevers (e.g., Lassa fever, Ebola viral disease)
   e. Vaccine preventable disease (e.g., Measles, Pertussis)

D. **GENERAL STRATEGIES TO REDUCE INFECTION RISK:**

1. Identify risk for acquiring and transmitting infections based geographic location, community and population served
   a. Receive public health alerts on community illnesses and trends from the California Department of Public Health (CDPH).
   b. Act as liaison between the medical center and the public health department.
   c. Attend monthly Association for Professional in Infection Control and Epidemiology (APIC) local chapter meetings with other facilities in our area.
2. Identify and control outbreaks
   a. Review of microbiology, immunology, molecular microbiology reports
   b. Institution of prevention and control measures as indicated (e.g., isolation, co-horting of patients and staff, improved hand hygiene, active surveillance cultures, assessment of environmental cleaning, enhanced environmental cleaning)
   c. Exposure follow-up (in conjunction with Employee Health)
3. Perform surveillance for healthcare-associated infections
   a. Follow CDC National Healthcare Safety Network (NHSN) definitions
   b. Comprehensive: inpatient-related and outpatient-detected
   c. Calculation/distribution of monthly infection rates and line listing of infected patients for each inpatient unit/service line
   d. Monthly and as needed analysis of potential for cross-transmission
   e. Targeted surveillance for home health/hospice infections
   f. Monitor incidence of healthcare-associated device-related or procedure-related infections
      i. Catheter-Associated Urinary Tract Infections (CAUTI)
      ii. Central Line-Associated Bloodstream Infections (CLABSI)
      iii. Ventilator-Associated Events (VAE)
      iv. Surgical Site Infections (SSI)
4. Conduct routine monitoring
   a. Biological indicators for sterilizers
   b. Endoscopes
5. Improve Hand Hygiene Compliance
   a. Support compliance monitoring and provide feedback to staff.
   b. Routinely evaluate the availability and acceptability of hand hygiene products.
   c. Provide just-in-time peer coaching.
   d. Provide frequent and tailored education on when and how to perform hand hygiene along with frequent visible reminders.

e. Enlist organizational leaders to serve as role models.
f. Ensure commitment of leadership to achieve and sustain compliance of ≥ 960%.

6. Develop and Support Infection Control Liaison Program
   a. Unit-based staff, outpatient care services clinical staff, and ancillary care staff (i.e., EVS, FNS, Patient Transport) with focused infection control training provided by Infection Prevention.
   b. Responsible for assessing their unit's compliance with infection control policies/procedures and conducting performance improvement activities related to infection prevention (e.g., reducing device-associated infections, monitoring and improving hand hygiene compliance)
   c. Serves as the contact person to disseminate infection control information, updates, and answer staff questions
7. Ensure compliance with TJC National Patient Safety Goals
   a. Comply with WHO/CDC hand hygiene guidelines
   b. Prevent HAIs due to multi-drug resistant organisms (MDROs)
      i. Annual risk assessment for MDROs
      ii. Implement and assess prevention strategies outlined in this plan and under NPSG 07.03.01
   c. Assess compliance with evidence-based practices for prevention of central line-associated bloodstream infections
      i. Compliance with Central Line Insertions, Access, and Maintenance Bundle
      ii. Standardized insertion training and checklist for providers.
      iii. Chlorhexidine bathing in intensive care units, and for all patients hospital-wide with a central line.
      iv. Daily assessment for central line need
      v. Provide Central Line-Associated Bloodstream Infection rate data and prevention process measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians
   d. Assess compliance with evidence-based practices for prevention of surgical site infections
      i. Ensure patient education provided in Pre-op visit. Use LMS for staff education.
      ii. Promote standardized, evidence-based practices for patient skin preparation prior to surgery.
      iii. Ensure Peri-Operative Services and Anesthesia infection control policies support prevention strategies.
      iv. Trend surgical procedure specific infection rates and unit rates and provide feedback to key stakeholders
   e. Implement evidence-based strategies for prevention of catheter-associated urinary tract infections
      i. Staff education regarding aseptic insertion of catheter
      ii. Insertion order must include indication for catheter
      iii. Daily assessment for urinary catheter need
      iv. Appropriate maintenance of indwelling urinary catheters
      v. Perform periodic audits on Indwelling Urinary Catheter Maintenance compliance and removal protocol and disseminate process measures on compliance to unit leadership quarterly.
8. Manage HAIs as Sentinel Events When Indicated
   a. Review all HAIs for indications of an unanticipated death or permanent loss of function
   b. Notify Risk Management of suspected sentinel event
   c. Participate in root cause analysis and follow up as needed

9. Construction Rounds and Construction Risk Assessment Meetings
    a. Walking rounds with Facilities Engineering monthly to active construction and renovation sites in the medical center and on an as needed basis.
    b. Attend construction meetings held by Facilities and Contract services.
    c. Review blueprints and risk assessments for all new construction and renovations in clinical areas.
10. Infection Control Rounds
    a. Evaluate compliance with infection control policies/practices.
    b. Written recommendations to manager with their follow-up documented.
11. Policy Review and Revision
12. Committee Participation: Refer to Infection Prevention Program Policy for committee information.
13. Periodic Comprehensive TB Risk Assessment
14. Consultation, Education/Training
    a. In-services, presentations, educational material to staff, visitors/families, medical staff, contract employees, students, and volunteers
    b. Computer-based training modules
    c. Educational videos
    d. Newsletter articles
    e. Educational materials (e.g., brochures, booklets)
    f. On-call availability 24/7 for Infection Prevention consultation
15. Additional Strategies to Reduce Infections for the Immunosuppressed Patient (e.g. absolute neutrophil count [ANC<1000], agranulocytosis)
    a. Ideally a private positive pressure room
    b. No live plants or fresh flowers
    c. Patient must wear tight-fitting surgical mask when outside room
    d. Child visitor restrictions during influenza and RSV season
16. Additional Strategies for Home Health and Hospice
    a. Trend analysis of wound infections, device-related infections (urinary catheter-associated UTIs and central line-associated bloodstream infections)
    b. Promote immunizations to prevent respiratory infections: influenza and pneumococcal pneumonia vaccines (as recommended by ACIP)
17. Additional Strategies for Outpatient Care Services
    a. Since most patient encounters with the healthcare system now take place in outpatient settings, TCMC will maintain infection prevention programs in Outpatient Care Services, and this will include
    b. Training and monitoring of practices on:
        i. the basic principles of disease transmission and the methods to prevent transmission
        ii. Safe injection practices and proper use of single use and single patient devices/ medications
        iii. principles of asepsis and hand hygiene
        iv. OSHA Bloodborne Pathogen Standard
        v. the principles of disinfection and sterilization
        vi. TB and respiratory protection per OSHA

E. SPECIFIC STRATEGIES TO ADDRESS INFECTION RISKS:

1. Based on the Facility Risk Assessment, the following strategies will be employed in FY24 for elements with scores of >6:
    a. ~~Central line Bloodstream infections (CLABSI)~~**Environmental Cleanliness-Terminal Cleaning failure**
        i. **Staff education and competency check off**~~Multi-disciplinary workgroup~~

ii. ~~Vascular access assessment~~**Weekly documented IP oversight**
iii. Implementation of ~~central line decision tool~~**unit specific terminal cleaning checklist**
~~iv. Implementation of ICU nasal decolonization~~

b. Personal Protective Equipment (PPE) Compliance
i. Compliance monitoring
ii. Staff education and competency check-off

~~ii.~~

F. **EVALUATION OF PLAN EFFECTIVENESS:**

1. Statistical analysis of infections
2. Trend analysis of infection rates
3. Healthcare-acquired infection rates to include home health.
4. Monthly infection reports to nurse managers, clinical directors, infection control liaisons
5. Quarterly infection reports to Infection Control Committee
6. Infection Control rounds report and annual compliance assessment
7. Support Employee Health Services to monitor compliance with required and recommended immunizations
8. Annual assessment of communicable disease exposures with trend analysis
9. Annual risk assessment for MDROs with trend analysis
10. Periodic assessment of process measures with staff feedback
    a. Evidence based processes to prevent surgical site infections
    b. Evidence based processes to prevent catheter associated bloodstream infections
    c. Evidence based processes to prevent catheter associated urinary tract infections
    d. Evidence based processes to prevent *C.~~lostridioides~~ difficile* infections
    e. Evidence based processes to prevent ventilator associated events
    f. Hand hygiene compliance
    g. Isolation precautions compliance

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

1. Infection Control Policy: Infection Prevention Risk Assessment
2. Infection Prevention Risk Assessment Table

H. **REFERENCE(S):**

1. APIC Text of Infection Control and Epidemiology, 2021.
2. Joint Commission, Hospital Accreditation Standards, Chapter: Infection Prevention and Control, www.jointcommission.org
3. CMS Conditions of Participation: IC **(reviewed 01/24)**
4. Title 22, Calif. Code of Regulations **(reviewed 01/24)**

Risk	Priority	Data Source	Goal	2023	Goal met?	Prevention Strategies
MRSA HO BSI	Mod	LabID/NHSN	SIR: ≤0.5 (SIR) <1	2 cases (CY2023 SIR 0.74)	Not Met	Standard/Transmission based Precautions/HH/ASP Education on prevention Nasal decolonization for MRSA+ nares, screening on admit Continue to monitor and trend data
MRSA HO infections	Mod	LabID/NHSN	Less than IHI published rate of 3.95/1000 pt days. As of 2020: # of positives/total patient days (MRSA) x 1000 pt	0.11	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention Nasal decolonization for MRSA+ nares, screening on admit Continue to monitor and trend data
VRE HO BSI	Mod	LabID/NHSN	0-1 case (no published benchmark)	1 case	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention Antibiotic Stewardship Continue to monitor and trend data
VRE HO infections	Mod	LabID/NHSN	Trend lower or same (no published benchmark)	3 cases	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention Antibiotic Stewardship Continue to monitor and trend data

ESBL HO infections	Mod	Cerner	Trend lower or same (no published benchmark)	4	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene, Cleaning & Disinfection Patient Care Equipment Education on prevention Antibiotic Stewardship
CRE HA	Mod	Cerner	Trend lower or same (no published benchmark)	4	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene, Cleaning & Disinfection Patient Care Equipment Education on prevention Antibiotic Stewardship
C diff HO Standard Infection Ratio (SIR)	High	LabID/NHSN	SIR $\leq$0.7 (SIR <1)	1.3 (30% higher rates than the national average)	Not Met	Adhere to Standard/Transmission based Precautions HH with soap/water Education on prevention/testing per stool guidelines Antibiotic Stewardship Use bleach for terminal cleaning of Cdiff rooms & for any non-single patient use equipment. Bristal stool chart in Cerner RN documentation Continue to monitor and trend data
Poss/Prob Ventilator Associated Pneumonia (PVAP based on VAE definition)	High	DA2	Number of PVAP cases trend lower	3 cases/ SIR: 0.70	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention VAP bundle Real time review by RT of all ventilator associated event cases Continue to monitor and trend data

VAE Standard Utilization Ratio (SUR)	Mod	NHSN	SUR<1	0.78	Met	IP nurse monitors daily PEEP/FiO2 report and microbial report.RT to continue daily assessement for weaning off vent Daily assessment for Spontaneous Awakening Trials, Daily Utilization review
CLABSI	High	DA2/NHSN	SIR 0.5 (SIR <1)	0.41	Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention CLIP bundle compliance CLABSI bundle Real time review of each case by unit educator Continue to monitor and trend data
CAUTI	High	DA2/NHSN	SIR 0.75 (SIR <1)	0.83	Not Met	Adhere to Standard/Transmission based Precautions and Hand Hygiene Education on prevention Advocate Catheter removal/use external products CAUTI bundle Real time review of each case by unit educator Continue to monitor and trend data
Hand Hygiene compliance	Mod	Verge	>96%	95%	Not met	Adhere to WHO and CDC guidelines for hand hygiene Education (New employee orientation, netlearning) Education to MDs at meetings and Chief of Staff, Continue to monitor and trend data. Audit 40 moments/month by each unit Monthly feedback on HH rates to unit leadership/staff

SSI (All 40 types) Total (Superficial, Deep, Organ/Space)	High	NHSN	SIR<1	0.96	Met	Share findings with ICC, QAPI, MQPR, GVS and OR Committee ID Pharmacist review for antibiotic compliance IC to perform quarterly rounds (at minimum), or more often as needed with OR management in OR & SPD. Perioperative Surgical Home program implemented for elective colorectal surgeries Perform audits on SSI's with high SIR rates
Environment of Care rounds	Low	Verge	Infection control issues addressed in all EOC rounding (100% of the time)	80%	Not Met	Continue to have Infection Control rounds incorporated with EOC rounding Findings from EOC rounds reported to Manger of each unit to address Findings from EOC rounds are reported to appropriate committees
Infection Prevention Department Resources	High	TCMC P&P	2.0 FTE	2 FTE	Met	CIC Epidemiologist hired FT Sept 2023
Reportable Diseases	Mod	Cerner/DA2	100% compliant with reporting requirements	100%	Met	Cerner Worklist identifies most reportable conditions, Cerner communication is continuously getting more streamline for accurate IP reporting.
Sterilization	Mod	Surgical Services	Zero Biological Indicator positives	0	Met	Continue to audit SPD & OR and report data to ICC
HLD	Mod	Surgical Services	Condense areas that do HLD to only SPD and US (trophon)	compliant	Met	IP & OR director doing weekly rounds to ensure compliance. Annual competency done on staff performing HLD Continue to monitor and report at ICC

ICC meetings	Mod	IP Dept	Quarterly meetings at minimum	5	Met	Continue to pre-schedule ICC meetings quarterly at minnimum. Meetings changed to every 2 months.
Emergency Preparedness	Mod	IP Dept	Participate in Disaster Management committee and any County drills related to IC	Yes	Met	Continue to be member of Disaster Management committee. Infection Prevention & Control is available for any IC issue. COVID-19 pandemic continued through April 2023. Infection Prevention & Control staff will continue to support and participate in all ways to prevent COVID transmission to staff, patients and other stakeholders of Tri City Medical Center.

1. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. As of 2022, the largest San Diego County racial/ethnic groups are White (43.4 %) followed by Hispanics (35%) & Asian (13.1%). Approximately 22.6% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment. Approximately, 39.4% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population.

E. LOCATION OF ALL SERVICES WITHIN ACUTE CARE SETTING

Lower Level				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
	Assembly Rooms			
	Cafeteria			
	Employee Health			
	Medical Records			
	Pharmacy			
	Sterile Processing			
	Quality/Risk/Infection Prevention			
Level 1				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
North Wing	Acute Rehab	X		
South Tower	ICU	X		
Pavilion	Cardiology Services		X	X
1st floor	Emergency		X	
1st floor	Laboratory			X
1st floor	Pulmonary Rehab		X	X
1st floor	Radiology	X	X	X
Level 2				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
South Tower (2E/2W)	Patient Rooms	X		
Pavilion (2P)	Patient Rooms	X		
Level 3				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
Center Tower	PCU (Forensics)	X		
Pavilion (3P)	Patient Rooms	X		
South Tower (3E/3W)	Patient Rooms	X		
Level 4				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
Pavilion (4P)	Patient Rooms	X		
South Tower (4E/4W)	Patient Rooms	X		

1. According to the US Census Bureau 2022 QuickFacts, the demographic information on the three cities most often served by TCHD is listed below.

City	Median income	Total # residents	White	Hispanic	Asian	African American

Oceanside	$ 84,373	174,068	58.4%	37.7%	7.2%	4.3%
Vista	$ 80,703	98,381	57.1%	49.2%	5.1%	3.3%
Carlsbad	$ 133,341	114,746	74.2%	16.6%	9.7%	1.2%

2. Tri City Medical Center Patient Characteristics for Fiscal Year 2023
   a. Patient Census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	98.2	5.33	35,135
ICU*	11.4	5.6	4,143
NICU	4.8	9.56	1,770
Rehab Serv.	5.0	9.7	1833

   i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.
   b. In acute care FY 2023, the three largest age groups are age 60-69 (19%), 70-79 (20.8%), and 80-89 (15.5%).
   c. 76.8 percent (6,571) of Emergency Department patients were admitted to the hospital in FY2023.
3. TCHD's primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:
   a. Obstetrics
   b. Newborns & Neonates
   c. Infectious & Parasitic Diseases
   d. Circulatory System
   e. Musculoskeletal & Connective Tissue
   f. Nervous System
   g. Respiratory
   h. Digestive System
   i. Kidney & Urinary Tract
   j. Hepatobiliary System & Pancreas

~~4.~~ ~~Top three Inpatient Surgical Procedures (Fiscal Year 2023): Esophagogastroduodenoscopy (EGD), Ureteroscopy and Spinal fusion (FUSN).~~

~~5.~~**4.** ~~Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY 2021 in Home Care:~~

~~**Average LOS**~~	~~**Top Payers**~~	~~**Top Primary DX Categories**~~
~~5.24 days~~	~~Medicare- 54.6%~~ ~~Medi-cal 26.4%~~ ~~HMO/PPO 14.6%~~	~~-Factors influencing Status/Sup Class~~ ~~-Injury/Poisoning~~ ~~-Circulatory (not HTN, HF or CVD)~~ ~~-Respiratory (COPD)~~ ~~-Musculoskeletal/Connective Tissue~~ ~~-Respiratory (not COPD)~~ ~~Circulatory-CVD~~ ~~Genitourinary~~ ~~1. Other health services for specific procedures and after care~~ ~~2. All Other injuries excluding fractures~~ ~~3. Diseases of Cardiovascular System~~ ~~4. Diseases of Respiratory System excluding complications of care~~ ~~5. Complications of surgical and medical care~~

F. **EMPLOYEE HEALTH:**

1. The Employee Health department at TCMC works collaboratively with the Infection Prevention Department to minimize the spread of infectious disease to and from employees.
   a. The total number of employees who worked at this facility in CY 2023 was approximately 1,638.
2. The Employee Health department contributes to the prevention and control of communicable diseases by established policies and procedures listed in TCMC policies. Together with Infection Prevention they work collaboratively in:
   a. Investigating and monitoring exposures to communicable disease and illness.
   b. Establishing pro-active policies and procedures for management of employee infection risks related to disasters, bioterrorism, and emerging pathogens.
   c. Establishing guidelines for work restrictions due to communicable disease.

G. **REVIEW AND EVALUATION OF FY2023 HOSPITAL SURVEILLANCE:**

1. See related document: Infection Prevention Program Plan

H. **RISK ANALYSIS FOR FY 2023:**

1. See related document: Infection Prevention Risk Assessment Table

I. **GOALS, OBJECTIVES, STRATEGIES, EVALUATION:**

1. The goals, objectives and strategies are described in the annual Infection Prevention Program Plan.
2. Using the risk analysis and the summary of healthcare-associated infection surveillance outcomes, prioritized risks are identified based on their nature, scope, and impact on the care, treatment, and services provided.
3. Goals and objectives, with specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure, surveillance and monitoring activities, education and training programs, environment and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application and/or duration depending on the specific risk issue, the care setting(s) and environment. See:

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

1. Infection Control Policy: Infection Prevention Program Plan
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
3. Infection Control: Infection Prevention Risk Assessment Table

K. **REFERENCE(S):**

1. County of San Diego Public Health & Human Services Agency, Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/ (reviewed 01/24)
2. APIC Text of Infection Control and Epidemiology, 2021.
3. https://www.census.gov/quickfacts/fact/table/missionviejocitycalifornia,orangecountycalifornia/PST045217 (Reviewed 01/24)
4. Joint Commission, Hospital Accreditation Standards **(reviewed 01/24)**
5. CMS Conditions of Participation: IC **(reviewed 01/24)**
6. Title 22, Calif. Code of Regulations **(reviewed 01/24)**
7. Health and Safety Code **(reviewed 01/24)**
8. CDC Guidelines as listed **(reviewed 01/24)**
9. CDPH AFL 09-07 (reviewed 01/24)
10. FDA 21 CFR Part 1271 (reviewed 01/24)
11. County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics-Fact Sheet 2022 (01/24). Retrieved from: http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/
12. **https://datausa.io/profile/geo/san-diego-county-ca/**

13. https://www.sandiegocounty.gov/hhsa/statistics_demographics.html
14. https://www.california-demographics.com/san-diego-county-demographics

	LIKELIHOOD	SEVERITY	PREPAREDNESS	RISK SCORE
	1(low)-5(high)	1(low)-5(high)	1(low)-5(high)	(Likelihood x Severity)/Preparedness
GEOGRAPHY/COMMUNITY				
Viral Hemorrhagic Fevers (e.g . Ebola virus, Lassa fever)	12	5	32	1.75 0
Outbreaks with vaccine preventable diseases (e.g., pertussis, measles)	23	4	3	4 02.7
Legionellosis	3	3	3	3.0
SARS-CoV	4	4	54	4 03.2
Novel influenza virus	43	4	35	4 03.2
FACILITY				
Infection Types				
CLABSI	35	4	43	6 73.0
CAUTI	35	3	43	2.255 0
C.difficile	4	3	3	4.0
SSI	43	4	3	5 34.0
Pneumonia	34	4	32	84.0 0
CRE	24	4	3	5 2.73
Influenza	4	3	4	3.0
Norovirus	3	4	43	34.0
RSV	3	2	4	1.5
Aspergillus	23	4	3	4 02.6
Candida auris	23	5	33	5 03.3
VRE	3	2	4	1.5
MRSA	3	32	4	1 52.25
Equipment Related Risks				
Inadequate disinfection/Sterilization of medical devices-(failure)	3	4	34	34 0
Cleaning of common equipment—wet contact time (failure)	32	4	43	24 0
Unsafe injection practices	3	4	4	3.0
Pathogen Exposure Risks for Patients and Staff				
MDROs (multi drug resistant organisms)	3	3	4	2 253
C. difficile	43	3	4	2 3.03
Influenza –Seasonal	2	3	4	1.5
Infestations (Scabies, Lice, bed bugs)	34	3	4	2.253 0
Tuberculosis	3	4	4	3.0
Communicable Diseases(COVID-19)	4	3	54	3 02.4

TCMC 20232 IP Risk Assessment

Internal Environmental Risks				
Construction or Renovation Projects	~~35~~	3	3	~~5.0~~3.0
Laundry and linen problems	3	3	4	2.~~25~~3
Medical Waste mishandling	3	4	4	3.0
Mold	3	4	3	4.0
Water Intrusion/ Disruption	~~45~~	4	~~33~~	~~6.75~~.3
Environmental cleanliness- terminal cleaning failure	~~55~~	~~44~~	~~33~~	~~6.75~~.7
Clean supplies and equipment are not stored appropriately	3	3	3	3.0
Safe Food Handling: cool down logs, labeling	~~43~~	3	4	~~2.33~~.0
Ice Machines – schedule for cleaning Ice containers	3	4	3	4.0
Employee Related Risks				
Hand Hygiene (non-compliance)	5	3	3	5.0
PPE (non-compliance)	~~45~~	4	3	~~6.75~~.3
Needlestick: Bloodborne pathogen exposure	~~35~~	4	4	~~5.0~~3.0
PAPRs (non-compliance)	3	~~43~~	~~43~~	3.0
Unidentified TB patients in Emergency department & direct admit	3	4	4	3.0

Low = < 3

Medium = 3 – 6

High = >6

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL
POLICY

ISSUE DATE: 09/01 **SUBJECT:** Required Reporting

REVISION DATE: 06/14, 02/18, 12/20

Department Approval:	**~~08/20~~01/24**
Infection Control Committee Approval:	**~~08/20~~01/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/20~~02/24**
Administration Approval:	**~~12/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/20**

A. **PURPOSE:**

1. To promote consistent reporting practices of Reportable diseases required by Title 17, California Code of Regulations for Reportable Diseases and to assist the hospital Infection Control Program to intervene rapidly when appropriate. State law mandates when and how to report (i.e. in writing, by phone, or fax transmission) depending on the disease or condition.

B. **PROCEDURE:**

1. Completing the required reporting to the local public health officer is the responsibility of every healthcare provider (physician, podiatrist, nurse practitioner, physician assistant, registered nurse, nurse midwife, or medical examiner) whom knows of, or in attendance on a case or suspected case of any of the required reportable diseases or conditions.
   a. For inpatients, contact Infection Control at 760-940-5696 for reporting assistance.
2. A list of required reportable diseases for healthcare providers is listed on the Confidential Morbidity Report (CMR) available at SanDiegoCounty.gov.
3. The CMR can be used for most reports (see TB and HIV/AIDS below). Forms for reporting are available at the CMR website.
   a. Urgent information should be reported via telephone:
      i. Epidemiology: 619-692-8499
      ii. STD: 619- 692- 8501
      iii. Tuberculosis: 619- 692- 8610
      iv. For diseases that require "immediate" reporting on weekend/holidays contact 858-565-5255.
   b. ~~Most~~ **Some** diseases are required to be reported within one working day and can be mailed, faxed or telephoned, refer to the CMR for disease specific reporting time frames.
   c. Mail information to the County of San Diego, Health and Human Services Agency, Public Health Services, 3851 Rosecrans St. San Diego, California 92110. Please note the department (i.e. Epidemiology, STD, TB Control, or Immunizations branch).
   d. "Fax" information to:
      i. Epidemiology: 858-715-6458
      ii. STD: 619- 692- 8541
      iii. Tuberculosis: 619- 692- 5516
4. HIV infection and AIDS are reportable in California using the required form (not CMR). The clinical laboratory or physician can notify Infection Control to report via ~~SanDiegoCounty.gov~~**phone call and FedEx 24 hour delivery of medical records**.
      i. SDPH HIV Branch: 619-692-8505

4. ii. **24 hour Fed Ex delivery to: 6160 Mission Gorge Rd. Suite 400, MS-P491, San Diego, Ca. 92120.**

5. Tuberculosis (TB) reporting is mandated by the Gotch Bill (AB 804) and requires a special form via SanDiegoCounty.gov
   a. See the Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan for further TB reporting requirements. Notify Infection Control during regular work hours Monday through Friday, or the Administrative Supervisor during holidays and weekends for reporting assistance.
6. Clinical Laboratory
   a. Microbiology will telephone the San Diego County Health and Human Services for communicable diseases listed under Report Immediately or Report Within One Working Day.
   b. Infection Control will be immediately notified of positive- Acid-Fast Bacilli (AFB) smears or cultures and positive TB results in order for timely reporting and follow up.
   c. Suspected or known meningococcal infections will be immediately reported to Infection Control or the Administrative Supervisor on evening, night and weekends, and holiday shifts.

C. **EXTERNAL LINK(S):**
1. Confidential Morbidity Report (CMR): http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html
2. HIV/Aids Reportable Form: http://www.sandiegocounty.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html
3. Tuberculosis Reporting Form: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/tuberculosis_control_program/reporting.html

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: Mandatory Reporting Requirements, 236
2. Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan
3. Infection Control Policy: Bloodborne Pathogen Exposure Control Plan

E. **REFERENCE(S):**
1. Consent Manual (2019, 46th ed.)California Hospital Association
2. County of San Diego, Public Health Services Reporting Instructions and Requirements (Program specific Information through Community Epidemiology, Tuberculosis Control and Refugee Health Program, and the HIV, STD and Hepatitis Branch).**(Reviewed 7/23)**
3. https://www.cdph.ca.gov/Programs/PSB/Pages/CommunicableDiseaseControl.aspx
4. Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions* **(Reviewed 7/23)**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	**10/05**	**SUBJECT:**	**Continuing Medical Education (CME) Speaker & Honoraria Reimbursement**
REVISION DATE:	**05/09, 11/12, 12/15, 06/18, 03/19 03/20, 04/21, 12/22**	**POLICY NUMBER:**	**8710-604**

Medical Staff Department Approval:	**~~01/22~~01/24**
CME Committee Approval:	**~~10/22~~01/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/22~~02/24**
Administration Approval:	**~~12/22~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**
1. To outline the process utilized by the Continuing Medical Education CME Committee to determine honoraria, and reimbursement expenses paid to individual faculty, authors, planners, and activity support staff and volunteers.

B. **POLICY:**
1. Tri-City Healthcare District's (TCHD) CME Committee is responsible for approving funds for speaker honoraria.
2. The CME Committee Chairperson/designee is responsible for approving honoraria, and reimbursement expenses greater than $500.
3. Honorarium shall not be paid to the director of the CME activity, CME Committee members, presenters, authors, joint sponsor, members of the medical staff involved with the supported activity, or others involved with the supported activity. No other payment as aforementioned shall be provided.
4. Members of the medical staff, who provide educational presentations, may request reimbursement for their expenses, i.e., development of PowerPoint/slide presentation as outlined in the following procedure.

C. **PROCEDURE:**
1. The CME Coordinator may contact commercial support in an effort to secure an unrestricted educational grant.
   a. All commercial support funds shall be made payable to "TCMC Medical Staff Treasury".
2. The CME Coordinator shall inform the speaker of the approved, offered honorarium.
   a. The CME Coordinator shall obtain a completed W-9 form from the speaker.
   b. Upon completion of the CME activity, the CME Coordinator shall mail the honorarium check, "Thank You Letter", and a copy of the activity "Evaluation Summary" to the speaker.

D. **REFERENCE(S):**
1. ACCME Standards of Commercial Support – Standard 3.7.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05

SUBJECT: Educational Planning, Needs Assessment, Objectives and Evaluation of a Continuing Medical Education (CME) Activity-Ensure Content is Valid

REVISION DATE: 05/09, 08/12, 12/15, 06/18, 03/19 04/21, 12/22

POLICY NUMBER: 8710-600

Medical Staff Department Approval:	~~11/22~~12/23
CME Committee Approval:	~~10/22~~01/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/22~~02/24
Administration Approval:	~~12/22~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **PURPOSE:**

1. To outline criteria utilized for educational planning and evaluation of a Continuing Medical Education (CME) activity.

B. **DEFINITION(S):**

1. Prioritization Grid – a tool utilized to organize the educational needs of the medical staff and assigning a CME scheduling priority according to the impact topics have on performance, HWOP, Joint Commission functions, cultural/linguistic implications, and National Patient Safety Goals.
2. ~~2.~~ Plan Do Study Act (PDSA) model – Simple yet powerful tool for accelerating quality improvement
3. Professional Practice Gap – The difference between health care processes or outcomes observed in practice and those potentially achievable on the basis of current professional knowledge.

C. **EDUCATIONAL PLANNING – NEEDS ASSESSMENT:**

1. Annually our physician's learning needs are surveyed to: a) identify educational needs or professional practice gaps, and b) evaluate the performance of the continuing medical education component at Tri-City Healthcare District. This data is then summarized and provided to the CME Committee to use in planning educational activities and in determining the potential value of the activity.
2. Identified needs from multiple sources are used to initiate and support the planning process. Need documentation is the first step in planning a CME activity.
3. Each source of need requires a supporting document to use in setting methodology, design, objectives, and evaluation of the CME activity.

D. **EDUCATIONAL PLANNING – OBJECTIVES:**

1. Based upon the identified needs, the objectives are developed for each CME activity.
2. The purpose or objectives of the activity describes learning outcomes in terms of physician performance or patient health and are consistently communicated to the learner.
3. The target audience is identified and stated in all learning materials.

4. Background requirements of the prospective participants are listed when indicated.
5. Learning outcomes in terms of competence, performance and patient outcomes are indicated and communicated to the learner.

E. EVALUATION & IMPROVEMENT:

1. All educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by competence, performance and patient outcomes.
2. When applicable, educational activities are evaluated for effectiveness in meeting identified educational needs, as measured by practice application and/or health status improvement.
3. The overall CME program is evaluated regularly by the CME committee with review of its mission and activities of the previous year.
4. Improvements are made in the CME program by incorporating suggestions of the CME committee into the operating CME policies and procedures.
5. Outcomes in physician behavior which influence the health of the population are measured when applicable by repeated surveys or statistical review of morbidity data.

F. PROCEDURE:

1. Activity Request - Upon request, the CME Coordinator will provide the activity planner with a "Quick Tool for planning Accredited Continuing Education" from ACCME Tool kit form for AMA PRA Category I Credit™.
2. CME Committee Review/Approval Process:
   a. The CME Coordinator will submit the completed "Quick Tool for planning Accredited Continuing Education" form to the CME Committee for review/approval.
   b. A quorum of the CME Committee members has the authority to approve a CME Activity Request outside of committee via electronic mail response. The CME Coordinator will make a copy of the electronic mail responses and file with the "Quick Tool for planning Accredited Continuing Education".
   c. AMA PRA Category I Credit™ requests shall be granted at the discretion of the CME Committee. Utilizing the Peer Review form from the ACCME toolkit.
   d. The CME Committee may utilize prioritization grids and/or the FOCUS-PDCA tool in planning CME activities to organize and prioritize topics maximizing the impact CME activities have on physician competence, performance and patient outcomes.
3. Documents – The CME Coordinator may utilize the ACCME toolkit for each activity, and will provide the following documents to the activity planner following approval by the CME Committee:
   a. Faculty disclosure form for disclosure of relevant financial relationships with resolution declaration should a conflict of interest exists;
   b. Cultural diversity form;
   c. Content validation form;
   d. Commercial guidelines (ACCME Commercial Support Standards);
   e. W-9 form (if applicable)
4. Required Documents – The CME Coordinator shall ensure documentation is on file for each approved CME activity per the CME Checklist. The activity planner will provide the following completed and signed documents to the CME Coordinator. Note: AMA PRA Category I Credit™ will not be assigned to a course if the following are not provided in a timely manner before the course date.
   a. Faculty's curriculum vitae (mandatory);
   b. Faculty disclosure form (mandatory);
   c. Content validation form (mandatory);
   d. Original handout material, and/or electronic (PowerPoint) presentation (if applicable);
   e. W-9 (if applicable);
   f. Audio-visual (AV) requirements (if applicable);
5. Processing Time - Processing time for CME requests is typically 60-90 days.
6. Advertisement - All AMA PRA Category I Credit™ approved activities shall be advertised to the Medical Staff. The CME Coordinator will assure that the advertisements include:

a. Title of the activity and topics to be presented
b. Statement of desired outcomes
c. The CME accreditation and credit designation statement
d. Acknowledgement of educational grants or other financial contributions (if known at the time of the publication)

7. Relevant Financial Relationships (Ineligible Company) – Disclosure of relevant financial relationships will be provided at every CME activity. See Commercial Support and Prevent Commercial Bias and Marketing policy
8. Evaluations/Sign-In Sheets – An activity evaluation form and a sign-in sheet shall be provided at every CME activity where AMA PRA Category I Credit™ is awarded.
9. Faculty - The CME Coordinator shall summarize the evaluations and provide a copy of the evaluation summary, a letter of appreciation and honorarium (if applicable) to the speaker within four weeks of activity closure.
10. Learners – The CME Coordinator may send a follow-up e-mail to the learners six (6) weeks following the activity.
11. CME Committee – The CME Coordinator shall provide the CME Committee with a summary of evaluations.
12. CME Credit - The CME Coordinator shall provide TCHD Medical Staff members a copy of their CME records upon request.
13. Record Maintenance - CME records shall be maintained for a minimum of six (6) years.

G. REFERENCE(S):

1. *Accreditation Council for Continuing Medical Education (ACCME) Standard 1*
2. All recommendations for patient care in accredited continuing education must be based on current science, evidence, and clinical reasoning, while giving a fair and balanced view of diagnostic and therapeutic options.
3. All scientific research referred to, reported, or used in accredited education in support or justification of a patient care recommendations must conform to the generally accepted standards of experimental design, data collection, analysis, and interpretation.
4. Although accredited continuing education is and appropriate place to discuss, debate and explore new and evolving topics, these areas need to be clearly identified as such within the program and individual presentations. It is the responsibility of accredited providers to facilitate engagement with these topics without advocating for, or promoting, practices that are not, or not yet, adequately based on current science, evidence, and clinical reasoning.
5. Organizations cannot be accredited if they advocate for unscientific approaches to diagnosis or therapy, or if their education promotes recommendations, treatment, or manners of practicing healthcare that are determined to have risks or dangers that outweigh the benefits or are known to be ineffective in the treatment of patients.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	**10/05**	**SUBJECT:**	**Joint Providership/Co-Providership**
REVISION DATE:	**05/09, 08/12, 09/14, 08/18, 03/19 03/20, 04/21, 12/22**	**POLICY NUMBER:**	**8710-602**

Medical Staff Department Approval:	**~~01/22~~12/23**
CME Committee Approval:	**~~10/22~~01/24**
Pharmacy & Therapeutics Committee:	**n/a**
Medical Executive Committee Approval:	**~~11/22~~02/24**
Administration Approval:	**~~12/22~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**
1. To outline criteria utilized for Joint Providership or Co-Providership of a Continuing Medical Education (CME) activity.

B. **DEFINITION(S)**:
1. Joint Providership– A relationship between an accredited CME provider and a non-accredited provider, in which the accredited provider works in partnership with the non-accredited provider to plan and present CME activities in accordance with the mission of the accredited provider.
2. Co-Providership– A relationship between two accredited CME providers to plan and present CME activities.

C. **POLICY**:
1. The non-accredited organization should have as its primary interest the dissemination of health care information or the findings of medical research.
2. The non-accredited organization agrees to follow all procedures outlined by Tri-City Medical Staff, and contained in the CME Policy Manual.
3. The Course Director should be a physician with an affiliation in the non-accredited organization.
4. The program planning request should be received at least six (6) months before the scheduled date of the activity. Timing for the activity should not conflict with other CME activities sponsored by Tri-City Medical Center (TCMC).
5. Tri-City Medical Center CME planning forms are to be completed and submitted as part of the course file.
6. All promotional material shall follow Tri-City Medical Center's CME policies, and be submitted for approval to the CME Coordinator before being distributed. Appropriate accreditation statements will be used, and all materials must indicate joint sponsorship with Tri-City Medical Center CME as the accredited sponsor.
7. A course coordinator should be designated by the non-accredited organization to manage the administrative details.
8. All potential joint/co-providership relationships will be examined on their individual merits. Although all CME activities joint/co-providership with Tri-City Medical Center CME must comply with this policy, Tri-City Medical Center CME reserves the right to refuse to enter into a joint/co-providership agreement for any reason whatsoever, regardless of that organization's willingness to comply with this policy.
9. The responsibilities and role of the joint/co-provider will be clearly delineated in a letter of agreement between the joint/co-provider and Tri-city Medical Center CME. Tri-City Medical

Center CME has the right to withdraw from any activity if the joint/co-provider fails to meet its obligations as described in the letter of agreement, or fails to comply with Tri-City Medical Center CME policies and procedures.

10. Tri-City Medical Center CME will charge fees for its services. These fees and the terms for its payment will be mutually agreed upon and delineated in the aforementioned letter of agreement between Tri-City Medical Center CME and the joint/co-provider.
11. All commercial support for Joint/co-provider activities shall be obtained as unrestricted grants, and all aspects of commercial support should be disclosed prior to approval of the activity. The CME Coordinator acting in behalf of the CME Committee will administer commercial support.
12. Joint provider activities shall be consistent with Tri-City Medical Center's CME Mission Statement.
13. Tri-City Medical Center, through its CME Committee, shall participate in the planning and implementation of these activities. A representative from the non-accredited entity should attend the CME Committee meeting to discuss progress.
14. All activity expenses are the responsibility of the organization seeking joint providership. Evidence of a proposed neutral budget is to be completed before expenses are incurred. Tri-City Medical Center will withdraw from an activity if resources are inadequate for the development of a high quality educational product or activity.
15. Attendance information should be submitted to the CME Coordinator within two (2) weeks of the activity, in order to provide timely distribution of CME certificates.
16. The proposed CME activity cannot be advertised prior to CME Committee approval and the designation of CME credit.

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

1. Written Agreement for Joint Providership.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	**04/09**	**SUBJECT:**	**Regularly Scheduled Series (RSS)**
REVISION DATE:	**12/09, 11/12, 09/14, 08/18, 03/19 03/20, 04/21, 12/22**	**POLICY NUMBER:**	**8710-606**

Medical Staff Department Approval:	**~~01/22~~12/23**
CME Committee Approval:	**~~10/22~~01/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/22~~02/24**
Administration Approval:	**~~12/22~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/22**

A. **PURPOSE:**
1. To outline criteria and process for approving and evaluating outcomes for Regularly Scheduled Series (RSS).

B. **DEFINITION(S)**: A regularly scheduled Series (RSS) is planned to have:
1. A series with multiple sessions.
2. The series occurs on an ongoing basis (offered weekly, monthly, or quarterly).
3. The series is planned by and presented to the accredited organization's professional staff.
4. The series are only offered as directly-sponsored activities to the accredited organization's professional staff.

C. **POLICY:**
1. RSS conferences such as cancer conferences and cardiovascular conferences are approved on the basis of common needs and goals for each session for a one-year period.
2. Initial RSS Request: Required documentation to be provided to the Continuing Medical Education (CME) Committee at least 60 days before the first session is scheduled:
   a. Request for AMA PRA Category 1 Credit(s)™
   b. Planner and Faculty disclosure forms.
3. Continuing RSS: For regularly scheduled series conferences currently taking place with Category 1 credit, the planner shall submit on an annual basis to the CME Coordinator the Annual Evaluation and Outcomes form and a new Request for AMA PRA Category 1 Credit(s)™ and Faculty Disclosure form(s). A 60-day time frame for CME Committee review is encouraged.
4. Conference Planner: The conference planner is responsible for providing the following documentation to the CME Coordinator within 30 days of the session date:
   a. Session Case Selection & Outcomes form.
   b. Completed evaluation forms.
   c. Evaluation summary.
   d. CME Reporting Form.
   e. Attendance roster.
   f. Case summaries (if applicable).
   g. Copy of promotion materials (flyer).
5. Regularly scheduled series conferences must be at least 50 minutes in length for one (1) category 1 credit.

D. **EVALUATION – IMPROVEMENT:**

1. Learners will complete an annual RSS *Learner Evaluation* form. Results will be summarized and provided to the CME Committee.

E. REFERENCE(S):

1. Accreditation Criteria and Policies for Continuing Medical Education (CME) * with annual report.

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

MERP 2024~~3~~

Tri-City Medical Center

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Plan Purpose and Overview:

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

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

The (MERP Plan) includes:

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

Scope:

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

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Objectives:

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

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

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

Organization:

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

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Process of the Plan:

- **Plan Development:**

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

Members of the MERP Plan core team includes:

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

- **Plan Implementation and Assessment:**

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

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

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

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

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

➢ **Improvement Strategies:**

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

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

➢ **Implementation Strategies:**

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

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

➢ **Education and Awareness:**

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

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

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

Monitoring:

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

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

Reporting:

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

Annual Review:

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

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

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

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Prescribing							
Decrease number of duplicate medication orders	Profile review during pharmacist order verification TJC	12/2013 08/2015 06/2016 03/2019 11/2019 11/2020 04/2021 05/2022	Tracking duplicate orders and working in conjunction with Chief of Medical Staff to evaluate causes and improvement strategies Possible retraining of providers Cerner implementation: Providers are receiving alerts of duplicate medication Cerner Community Work Go-live April 2021	Pharmacy Staff Medical Staff Regulatory Nursing Staff Information Technology	Ongoing Data source development needed. Manual Audit: Auditing an average between 30 and 40 charts per month. 02/2023: Resume manual chart audits	Surveillance Quality Assurance & Performance Improvement (QAPI) Reports Pharmacy Reports Information Technology	06/2016: General consensus from pharmacists indicates there has been little improvement. Medical Quality has decided to include duplicate orders as part of the ongoing professional practice evaluation. Goal: 0 True Duplicate Therapy. 04/2017: Continues to be discussion at Med Staff level on proper review for duplicate meds. 07/2017: This will be part of the MD Optimization roll out. 01/2018: With further MD input improvements being made. Continue to evaluate. 02/2023: pending results of chart audits **01/2024: Continuing to find occasional duplicate therapies on chart audits, particularly as needed (PRN) orders (e.g., pain meds with the same pain scales without instructions for order of use, PRN saline flush orders, etc.). Pharmacists clarifying duplicate orders and reminding nurses, and physicians to check for duplicate therapies.**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Antimicrobial Stewardship	Antimicrobial Stewardship Program (ASP) Medication Safety Committee (MSC) Infection Control TJC	04/2020	Added recommended guidelines for use of antimicrobial agents on 2020 antibiogram Updated TDMS to PrecisePK Updated vancomycin and aminoglycoside dosing policies Updated renal dosing policy to include dosing by indication and by renal function Researched treatment regimens for COVID-19 and implemented ordering and verification procedures	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff Administration	02/2022, 07/2022, 08/2022: Updated TCMC Adult COVID management 05/2022: Started tracking days of therapy (DOT) of antifungal therapy and monthly medication use evaluations (MUEs) of remdesivir. Redid ASP pharmacist intervention categories in Cerner Community Works 06/2022: Created IV to PO and renal dosing daily reports for pharmacists to review 07/2022: Added preferred empiric regimens for selected disease states to 2021-2022 antibiogram 10/2022: Initiated pharmacist involvement in Outpatient Parenteral Antimicrobial Therapy (OPAT). 12/2022: Implemented quality improvement (QI) project: extended-infusion beta-lactams to decrease hospital length of stay (LOS) 02/2023: Updated vancomycin dosing protocol **to use Bayesian-derived AUC/MIC goal ratio of 400-600 for additional indications** ~~pending~~	ASP Committee P&T Committee Infection Prevention QAPI Pharmacy reports	Appropriate prescribing of empiric antimicrobial therapy Appropriate dosing of antimicrobials Appropriate monitoring of antimicrobials 05/2022: Presented ASP to TJC survey and passed 06/2022-01/2023: Improving number of IV to PO conversions. Auditing renal dosing of antimicrobials on a quarterly basis. MUE for remdesivir shows no instances of inappropriate prescribing so no need to evaluate further 01/2023: Created OPAT Collaborative Practice Agreement- pending approval 02/2023: Appropriate use of antimicrobials remains stable. Pending data of QI project: extended-infusion beta-lactam antibiotics- **QI project suspended due to too many confounding variables in the study design to make any meaningful conclusions.** **08/2023: Infection Prevention to provide education to Nursing and to work with Lab to come up with an algorithm to rule out**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					~~approval~~ **08/2023: Hospital-acquired Clostridioides difficile incidence (HA-CDI) above the national average. Analyzed cases during 2023 Quarter 2 and identified inappropriate testing and not following testing recommendations as a large contributor to the reported HA-CDI cases.** **11/2023: Update TCMC pneumonia guidelines for empiric therapy and add guidelines for empiric treatment for urinary tract infections (UTIs) and CDI- pending approval.**		**inappropriate stool samples sent for CDI testing (e.g., patient received laxatives within 48 hours of stool collection, patients who did not have 3 or greater stools documented in the past 24 hours before collection).** **10/2023: Approved and implemented Oral Vancomycin Prophylaxis (OVP) pharmacy procedure for prevention of HA-CDI in high-risk patients. Pending results for 2023 Quarter 4 after OVP implementation and Infection Prevention's efforts.** **11/2023: CDI guideline adherence by physicians and providers at TCMC from January to September 2023 was 62%.**
Prescribing restricted Antimicrobials	Chart Review ASP	05/2020	Increasing prevalence of resistant microbes with limited treatment options	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff	Limited ordering restricted antimicrobials to one dose stat Order reviewed by ID team Decreased and controlled the use of restricted antimicrobials 05/2022: Started performing monthly MUEs of meropenem and ceftazidime 12/2022: Microbiology lab implemented use of new rapid	ASP Committee P&T Committee Infection Prevention QAPI	Appropriate use of restricted antimicrobials 11/2022: Meropenem and ceftazidime now restricted to ID and ICU only due to reduced susceptibility compared to Scripps Encinitas and VA San Diego TCMC vs Scripps vs VA SD Ceftazidime: 87% vs 90% vs 95%

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
				Administration	diagnostic GenMark Blood Culture Identification (BCID) to help identify organisms and resistance genes within 2 hours		Meropenem: 89% vs 96% vs 99% 02/2023: Awaiting data to see if there is reduction in time to effective therapy and higher rate of antimicrobial de-escalation
Wrong dosing weights input in Cerner	MSC	09/2022 **01/2024**	Incorrect weights are being entered in Cerner. Often, the patient's weight in pounds is entered as kg, almost doubling the dose of weight-based drugs.	Pharmacy Nursing IT	Ongoing 10/2022: Reviewing events in Med Safety to provide education to nursing staff to input weights in the correct field (pounds vs kilograms) and having pharmacists double check weights with the nurse if the weight seems high or if there is a large discrepancy (Cerner fires a task for weight discrepancies in the multi-patient task list but difficult to find) **10/2023: Cerner implemented a global change in the workflow for documenting height/weight so that the measured height/weight field automatically populates the Dosing Weight field once signed.**	RL Reports Chart review	01/2023: Chart review still finding instances of incorrect weight. **01/2024: No reported instances of incorrect weights inputted into Cerner. However, pharmacists are finding that if the weight is updated from the initial measured weight, the new weight is not crossing over to the Dosing Weight field. Ticket placed with Cerner to look into this issue.**
Prescription Order Communication							
Improve	Audit by	07/2020	A multidisciplinary group	Nursing	Ongoing	Surveillance by	Medication Reconciliation

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Accuracy of Medication History and Reconciliation Process	Medical Staff 2023 National Patient Safety Goals (NPSG) **Leap Frog**	01/2023	has been put together to address improving the meaningfulness and accuracy of the medication history and reconciliation process from admission to discharge. With Covid-19 our 2 ED pharmacy technician's positions were eliminated. Educated nursing staff on performing the medication reconciliation upon admission and discharge 02/2023: Currently, physicians are not alerted through Cerner if there are changes to the patient's medication history. IT to investigate if this is in development.	Pharmacy Medical Staff IT	11/2022: Created 2 Medication History Pharmacy Technician positions Go-live November 2022 02/2023: Need to revise the process for medication history intake for when techs are not able to complete med history before a patient is transferred out of the ED and when the med history is updated after the physician has already reconciled a patient's medications. **03/2023: Revised the process so that if the medications are reconciled before the medication history intake technicians review a patient's medications, they are to alert the admitting physician or notify the pharmacist to alert the physician if there is a discrepancy from what is documented and what the patient reports.**	PI and reported to Medication Safety and P&T. Med Staff review for provider compliance of med reconciliation RL reports	reports showed ..... 04/2017: Further review on medication reconciliation not done by technicians needed. 07/2017: Audits show we often miss the last dose given info. Continue to evaluate process Transitions of Care program is ideal. From 07/2019 through 07/2020 medication history has been performed by providers only when needed and upon transition of phase of care. 01/2023: Still receiving med error reports related to incorrect medication reconciliation. **11/2023: Medication history documentation improved, especially with selection of correct formulation and communication to the physician. However, still finding lack of patient drug allergy reaction documentation. Provided feedback to medication history intake technicians to help improve drug allergy reaction documentation.**
Improve CPOE	ISMP	2019	Order Set Development	Nursing	Ongoing	Pharmacy	Increased CPOE Compliance

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
compliance rates		**05/2023**	needed for CPOE Order Sets updated regularly based on Current Guidelines and approved by P&T and MEC CPOE Compliance Rate Staff Education	Pharmacy Medical Staff	12/2020 **09/2023: Reported breakdown of CPOE rates by specialty and individual physician/provider in MSC to elucidate if there were any targeted areas for improvement to bring forward to either the Documentation Steering Committee or Medical Staff Office.** **11/2023: Note- TCMC extended downtime incident necessitated paper charting through most of November.**	Reports Community Works implementation on April 2021 Set the rate at 90% or greater Will analyze the reports post Cerner implementation **Cerner LightsOn Network reports**	Rate 01/2023: CPOE rates remain above goal through Quarter 4 of 2022 Continue evaluating **05/2023: After gaining access to Cerner LightsOn Network, found that there was a discrepancy between the CPOE rates reported in LightsOn versus those reported in Discern Analytics 2.0 (DA2). Contrary to the DA2 report which showed CPOE rates above the goal, LightsOn showed that the CPOE rate has been below the goal in the mid- to high-80% range. Upon closer inspection of the DA2 report, found that several thousand orders were missing from the DA2 report and it was also pulling in many non-pharmacy orders. Decision made to start reporting the LightsOn CPOE rates in MSC.** **11/2023: Med Staff unable to customize LightsOn report to be able to utilize it effectively for individual physician performance. May need to**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
							consider editing the DA2 report 12/2023: CPOE rates similar to rates prior to November 2023.
Medication shortage communication	CDPH	06/2019 02/2023	Shortages needed to be communicated and managed well	Nursing Pharmacy Medical Staff	Ongoing 12/2020 09/2022: Started publishing weekly drug backorder reports for ED physicians, later expanded to ICU. 02/2023: Expand backorder report distribution to all clinical managers and the nursing house supervisor so that nursing staff is aware of current shortages and alternatives	P&T Shortage Report Weekly backorder reports Discuss daily in pharmacy huddle	Shortages identified Coordination with the buyer Communication with med and nursing staff Looking for therapeutic alternatives Using CPS resources (Purchasing Analyst, Reports...etc., Using 503B for sterile compounds 02/2023: Lack of knowledge of current shortage resulted in treatment delay and revealed that communication needs to be improved **12/2023: Backorders and drug shortages continue to be an issue, but timely communication has been improved through announcements in leadership safety huddles and weekly backorder report distribution.**
Product Labeling, Packaging, and Nomenclature – n/a							
Compounding – n/a							
Dispensing							
Review Overrides	MSC TJC	01/2019 **11/2023**	A high rate of medication override	Nursing Staff Medical Staff	05/2020 Reviewed Medication Override	Monitoring override rate	Decrease of inappropriate override

Tri-City Medical Center
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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
	GACH				policy and list Last revision approved by P&T on 05/2020 Hired 2 ED pharmacist to review all ED orders 08/2022: Pharmacists resumed reviewing override reports **11/2023: Note- TCMC extended downtime incident necessitating universal Pyxis Medication Station override**		02/2022: Met goal <4% 01/2023: Override rate meeting goal and continuing to trend down **11/2023: Override rate goal met up until downtime. Expect override rate of 100% for any new orders placed since downtime initiated until Pyxis servers have been restored—still pending as of 01/2024.**
Dispensing the wrong medication	MSC	10/2022 **10/2023**	Identified wrong medication filled in the Pyxis. Reviews of med errors in 2022 showed other instances of medications dispensed incorrectly.	Pharmacy	Ongoing 11/2022: Provided education and reminder to pharmacy technicians to always utilize barcode scanning when filling the Pyxis. In the instance of barcode scan failure, technicians should get a witness to verify independently without confirmation bias that the correct medication is filled. Pyxis refills of high alert medications will require pharmacist verification instead of tech-check-tech. **10/2023: Identified several incidents of the wrong medication found in the Pyxis pocket. Incidents are largely related to training of new**	RL reports	10/2022-11/2022: Conducted a Failure Mode and Effects Analysis (FMEA) regarding the incorrectly filled medication. Reported findings to MSC, P&T, and pharmacy department 01/2023: No other reported instances of wrong medications dispensed but will continue monitoring. **01/2024: No other reported incidents but will need to continue ensuring that the education is incorporated into the training of all new pharmacy technicians.**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					pharmacy technicians. Individual technicians educated on proper procedure for loading/filling medications		
Distribution – n/a							
Administration							
Bar Code Scanning (Patient and Meds)	Leap Frog	01/2020 11/2022	Not meeting Leap Frog criteria for patients and medication bar code scanning Community Works reports showing both rates trending down 11/2022: RL reports of medication errors still showing errors related to not scanning, especially in ED.	Pharmacy Staff Nursing Staff Medical Staff	Utilized Pyxis BCS feature Educated nursing medical and pharmacy staff 11/2022: Resumed Medication Safety meetings to regularly report BMV rates. Nursing education to be provided in ED. 02/2023: May require ED pharmacist to educate nursing regarding BMV scans **11/2023: TCMC extended downtime incident necessitating paper charting and downtime procedures. Expect decreased scan rates due to interruption of normal procedures.** **01/2024: Resume close monitoring and reporting of BMV scan rates**	Pharmacy reports RL reports	Increased medication bar code scanning rate 01/2023: ED BMV rates still far below benchmark >95% set for inpatient units. 2022 BMV scan rates for inpatient units have increased from 2021. **05/2023: Inpatient units met goal of at least 95% for both patient and medication barcode scanning** **10/2023: ED met goal of at least 50% for both patient and medication barcode scanning** **12/2023: Overall scan rates decreased to below goal rates, likely due to disruption in usual processes during downtime.**
Guardrails Usage	ISMP MSC	10/2022	Discussed at Medication Safety Committee meeting 10/2022: Findings from Alaris on-site	Pharmacy Nursing	Ongoing 11/2022: Set up training sessions for Guardrails Suite Editor to update the data set. 11/2022-01/2023: Added new	Alaris reports Set Benchmark >95% Guardrails usage	02/2023: Released new Guardrails data set. Alaris pump remediation in progress to upgrade to V12.1.x Will need to evaluate once

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
			representative showed that there were several medications/therapies missing from the drug library and that the limits needed to be revised.		drugs and revised limits on existing drugs in the library 01/2023: Met with Alaris executive consultant who will set up clinical education and site visit in May 2023 to reevaluate Guardrails usage **10/2023: Released updated Guardrails data set based on review of quarterly Alaris Guardrails usage reports.**		upgrade has been completed **01/2024: Guardrails usage has increased from 73.05% in January 2023 to 85.53% in January 2024.**
Education ~~n/a~~							
Lack of detailed procedures for extended downtime	**ISMP TJC**	**11/2023**	**Existing downtime medication administration record (MAR) was found to be useful only for downtime lasting a few hours. It was not practical for an extended downtime event as RNs often forgot to write the administration dates on each page.**	**Pharmacy Nursing Medical Staff Clinical ancillary depts**	**11/2023: Pharmacy worked with Education to roll out a new four-day downtime MAR.**	**Paper Chart Audits**	**01/2024: Although some elements of documentation needed correction (e.g., missing initials/signatures on every page), documentation of medication administration dates largely improved with the use of the 4-day MAR.**
Monitoring							
Heparin for Impella device	MSC	01/2023	Medication errors regarding heparin for patients on Impella devices have been identified.	Pharmacy Nursing Medical Staff	Ongoing 01/2023: ICU pharmacists to check heparin purge solution and systemic heparin bags in the patients' rooms at least once daily and with each rate	RL reports Chart Audits	01/2023: Heparin for Impella Device protocol approved in P&T. Sodium bicarbonate purge fluid for Impella passed P&T, awaiting CPP approval. Awaiting implementation to

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					change of systemic heparin to ensure that the correct drug concentration is hanging and that they are running at the correct rates. Added sodium bicarbonate as alternative to heparin purge fluid in patients intolerant to heparin.		review efficacy **12/2023: Use of sodium bicarbonate purge fluid for Impella has decreased the potential for mistakes in heparin dosing. No further events reported.**
Use Strategies							
High number of opioid-related morbidities and mortalities in the community	California Department of Healthcare Services (DHCS) CA Bridge TJC	11/2022	Received approval for grant from DHCS to start an opioid stewardship program. May be renewed annually.	Pharmacy Nursing Medical Staff Quality IT	Ongoing 01/2023: Pending approval for the creation of a Substance Use Navigator position. Exploring possibility of starting a medication-assisted treatment (MAT) program to help patients with opioid use disorder **03/2023: Established a Collaborative Practice Agreement with Dr. Emad Tadros for MAT therapy-pending implementation.** **05/2023: Hired Substance Use Navigator (SUN) to help connect patients and physicians/providers with resources and raise awareness/provide education regarding MAT.** **06/2023: Order set drafts for buprenorphine induction and**	Pharmacy Reports Chart Audits	02/08/2023: First Opioid Stewardship Committee meeting was held **01/2024: Since the establishment of the SUN program in late May 2023 through December 31, 2023:** • **472 ED/hospital encounters where a patient was seen by the SUN** • **194 ED/hospital encounters where the SUN facilitated patient referral to follow-up mental health treatment** • **181 ED/hospital encounters where a patient was treated with buprenorphine** • **321 naloxone kits distributed to patients/staff at discharge**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

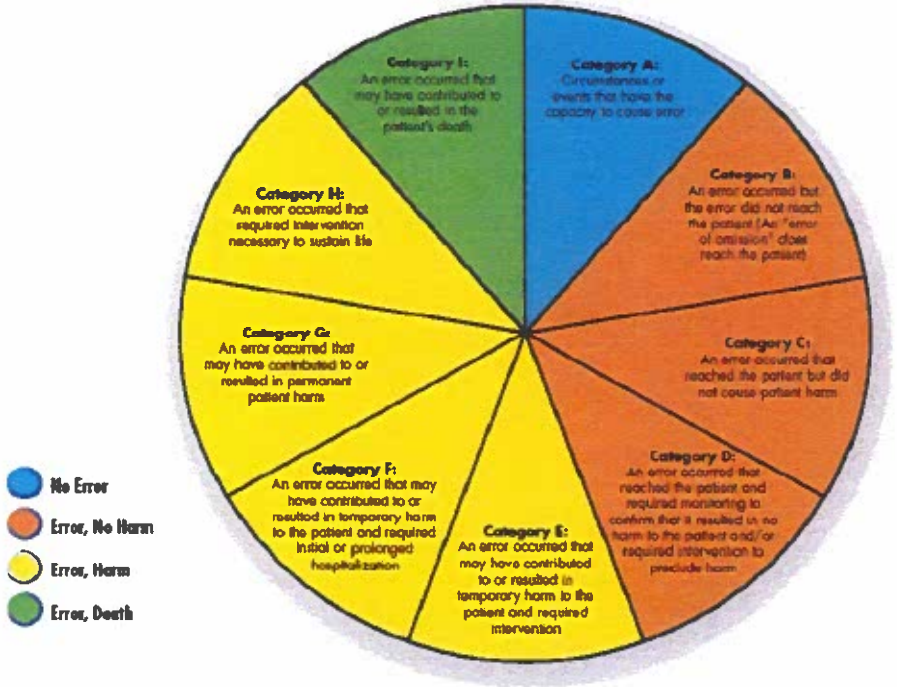
Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					maintenance presented in OSC. SUN looking into restarting the naloxone distribution program		**since the naloxone distribution program was reinstated in June 2023.**
Technology Elements							
Lack of Anesthesia Cart in the OR, Accountability/ Inventory Control	MERP Audits of Shingle sheets	12/2019 12/2022	Review of Overrides and Discrepancies Pending Approval for Anesthesia Carts Non Scan Report	Pharmacy Nursing Medical Staff Information Management (HIM) Nursing Cardio-pulmonary Laboratory Pharmacy Medical Staff IT Quality	Ongoing Pending Approval Anesthesia Carts purchased 01/2023: Met with ICU manager and OR educator regarding missing OR charges and missing drug administration charting. Found that some medications are not in the Anesthesiology Drug Formulary so they cannot be added to the Anesthesiology Record. IT to work on adding these to the formulary. 02/2023: Met with representative from the anesthesiology group to discuss better documentation and accountability/inventory control. Missed OR charges, undocumented narcotic waste, and undocumented medication administration will be reported regularly to the representative from the anesthesiology group who will follow up with med	Pharmacy Reports Chart Audits	12/2022: Still finding undocumented narcotic waste, missed OR charges, and undocumented medication administration. 01/2023: Unable to amend OR record post-discharge to add missing medication administration and charges. IT working on it. **12/2023: Pending implementation of new restocking process**

Tri-City Medical Center
Medication Error Reduction Plan: 20243 Plan & Goals

Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					staff. **10/2023: Met with anesthesia tech and OR leadership to discuss restocking medications from the main Surgery Pyxis instead of storing medications in anesthesia carts and the implementation of medication trays for mobile anesthesia carts to increase**		

NCC MERP Index for Categorizing Medication Errors

Addendum A



Definitions

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

Monitoring
To observe or record relevant physiological or psychological signs.

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

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

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES POLICY

ISSUE DATE: 08/97

SUBJECT: Pulmonary – Scope of Services

REVISION DATE(S): 08/97, 01/00, 09/03, 08/06, 09/08, 09/09, 11/11, 05/12, 09/17

Department Approval:	~~06/20~~01/24
Division of Pulmonary Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/20~~02/24
Administration Approval:	~~12/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval Date(s):	12/20

A. **OVERVIEW OF THE DEPARTMENT:**

1. The department of Pulmonary Services provides diagnostic and therapeutic services to inpatients, outpatients, and emergency department patients under the direction of a licensed pulmonary physician. Services are provided to neonates, infants, adolescents, adult and geriatric age groups. Service settings include all hospital areas. Pulmonary services provide a 24-hour/7 day service designed to meet the needs of our patients.

B. **DIAGNOSTIC SERVICES INCLUDE:**

1. Pulmonary function testing (outpatients scheduled 2 days/week: Tuesday & Thursday and inpatients as ordered). If there is a need, more days will be opened to serve community and patient needs.
2. Non-invasive oxygen assessment (Pulse Oximetry).
3. Home oxygen assessment.
4. Blood gas sampling and analysis.
5. Sleep screening (limited sleep screen– inpatients only).
6. Bronchoscopy.
7. CPAP set up and education

C. **THERAPEUTIC SERVICES INCLUDE:**

1. Patient pulmonary assessment.
2. Patient respiratory education.
3. Medical gas administration.
4. Aerosol therapy.
5. Hyperinflation therapy.
6. Pulmonary hygiene.
7. Airway maintenance and support.
8. Ventilatory support.
9. CPR.
10. COPD Discharge Education

D. **PROVIDERS OF SERVICE:**

1. All providers of respiratory therapy are appropriately oriented to the department and are licensed as required by law. Respiratory Care Practitioners (RCPs) acquire additional training and continuing education to ensure the proper care of patients. RCPs function under the direction of a medical director who specializes in pulmonary medicine. The medical director acts in that role for

two years as described in the medical center by-laws. RCPs also function under the direction of an operations manager and director.

2. The pulmonary services department staff work in 12-hour shifts. The number of staff scheduled each shift is based on the total workload calculated from the Respiratory Therapy Workload Summary report. .
3. Qualified RCPs are available 24 hours a day, 7 days a week.
4. Members of the pulmonary management services team include the following:
   a. Pulmonary Operations Manager/Clinical Educator
5. The department of pulmonary services is composed of professional, technical, clerical, and support staff in the following categories:
   a. Director
   b. Pulmonary Operations manager /Clinical Educator /-Critical Care Specialist/Adult and Neonatal Leads Registered/Certified pulmonary function technologists
   c. Registered respiratory therapists (RRTs)
   d. Certified respiratory therapists (CRTs)
   e. Cardiopulmonary assistants (equipment technicians)
6. Job descriptions are on file for each of the above job categories.

E. **EQUIPMENT:**

1. The pulmonary services department provides services utilizing medical equipment that is maintained in proper operational condition per preventative maintenance schedules and manufacturer's recommendations. Equipment inventory includes disposable and non-disposable equipment.

F. **STANDARDS AND PRACTICE GUIDELINES:**

1. Effective and efficient patient care is provided based on current standards of respiratory care and practice. TCMC pulmonary services adheres to federal and state regulatory imperatives and standards including the Respiratory Care Practice Act, Title 22, and Title 17, Center for Disease Control (CDC) and OSHA, and JCAHO. Patients can expect care that is delivered in a manner consistent with the American Association of Respiratory Care (AARC) Guidelines for Therapy whereby patients are assessed so that individual needs are met. The patient is evaluated to ensure that therapy is appropriate, indicated, and objectives clearly defined.
2. Patients and patient families can expect to be treated with dignity and respect (per "Patients' Rights") by the RCPs who also provide education and explanation of services for their customers.
3. In addition to the national guidelines, policies/procedures and protocols are based on expert consensus, and community standards. Policies and procedures are reviewed and revised as needed to accommodate new evidence, standards, and/or guidelines. Final versions are communicated to the staff through email, staff meetings, and daily huddles on each shift.
4. All policies and procedures are posted online after submitting to house wide review and board approval.

Tri-City Medical Center

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Oceanside, Californ

REHABILITATION SER

RETIRE: NOT REQUIRED POLICY AND NICU OT NO LONGER PART OF REHAB DEPARTMENT; OT FUNCTIONS WITHIN THEIR SCOPE OF PRACTICE

ISSUE DATE: 07/97

SUBJECT: NICU Scope and Qualifications

REVISION DATE(S): 07/98, 01/06, 01/09, 03/12

POLICY NUMBER: 505

Rehabilitation Department Approval:	~~11/18~~11/23
Perinatal Collaborative Practice Committee Approval:	~~01/19~~11/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/19~~02/24
Administration Approval:	~~03/19~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

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

~~1. Provides~~**Rehabilitation Services provides** ~~developmental and feeding evaluation and treatment in the NICU and newborn nursery per physician orders within the scope of California Physical Therapy, Occupational Therapy and Speech Therapy practice acts~~**Practice Acts**~~, and as limited by Tri-City Medical Center's Policies and Procedures and Standards of Practice and as an area identified as advanced practice.~~

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

~~1. Assessment/Therapy~~

~~**The provision of rehabilitative therapies (Physical Therapy, Occupational Therapy, Speech Language Pathology) in the NICU will adhere to all applicable Women and Newborn Services Neonatal Intensive Care Unit policies and procedures including but not limited to:**~~

- ~~**Standards of Nursing Care – NICU**~~
- ~~**Developmental Supportive Care in the NICU**~~
- ~~**Cue-Based Feeding**~~

~~**Occupational Therapy:**~~

- ~~**In accordance with the American Journal of Occupational Therapy *Occupational Therapy's Role in the Neonatal Intensive Care Unit*:**~~
  - ~~**"Knowledge of neonatal neurodevelopment, neurobehavioral organization, the musculoskeletal system, family attachment and bonding, infant and parent or caregiver mental health, stress management, and advanced age-appropriate feeding practices and techniques are essential."**~~
  - ~~**"Occupational Therapists interested in practice in the NICU must undergo extensive training and mentoring before practicing, and they require supervision and ongoing mentoring as they begin to work in this environment."**~~
- ~~**Qualifications:**~~
  - ~~**Valid and current California Licensure in Occupational Therapy**~~
  - ~~**Adherence to all standards as outlined by the American Occupational Therapy Association *Specialized Knowledge and Skills for Occupational Therapy Practice in the Neonatal Intensive Care Unit***~~
  - ~~**For independent practice:**~~

- ~~Have a California Children's Services (CCS) paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.~~
- ~~Have the Certified Neonatal Therapist (CNT) designation or be CNT eligible and~~
- ~~Have the California Advance Practice approval for Swallowing Assessment, Evaluation, or Intervention~~

~~For licensed clinicians who do not have the above qualifications for independent practice and require supervision:~~

- ~~Completion of application with California Children's Services (CCS) to be a paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.~~
- ~~Demonstrate proficiency in evidence based practice in both didactic theory and daily practice through department specific mentorship program documentation and~~
- ~~Documentation of services provided requires co-signature from a licensed clinician who meets the criteria for independent practice~~

~~Must demonstrate ongoing competency in both continuing education courses specific to the NICU and through peer review.~~

~~Initiation of Occupational Therapy services will occur under the following conditions:~~

~~Patient medically cleared and stable to start services, including but not limited to:~~

- ~~Patient off ventilator or respiratory assistance~~
- ~~Patient discontinued from central lines (i.e. UAC, UVC, PICC)~~
- ~~Patient greater than 26 weeks estimated gestational age at birth (EGA)~~

~~With valid, individualized, specific and timely orders from the referring physician and~~

~~After assessment by attending physician who has identified impairments or potential impairments in one of the below areas and~~

~~After failed attempts by nursing to address said impairments or potential impairments~~

~~Provision of consultative services include evaluation and intervention in the following areas:~~

~~Neurobehavioral Assessment including a neuromuscular exam, analysis of movement patterns, joint range of motion, – Observe, identify, and support according to the infant's capabilities: autonomic regulation, motor regulation, state transition and regulation, attention and interaction skills, self-regulation, and behavioral organization,~~

~~Neuromotor – Observe, identify, and support according to the infant's capabilities: neurodevelopmental positioning, neurodevelopmental handling, development of normal movement patterns, normal reflex development, normal tone development and tonal changes~~

~~Musculoskeletal– Observe, identify, and support according to the infant's capabilities: development of normal posture and alignment, prevention of the effects of iatrogenic deformities, development of antigravity movements and symmetric strength, physiological tolerance of activity~~

~~Sensory – assess, facilitate, and promote protection of the typical progression of the sensory response testing and systems (tactile, proprioceptive, vestibular, gustatory, olfactory, auditory, visual): facilitate and support sensory integration, provide pain management, provide nonpharmacological interventions~~

a. **Feeding – facilitate and support** oral mechanisms/feeding evaluation. – **sensory-motor development, prefeeding skills, and transition to oral feeding through:**

b. Initial and ongoing positioning assessments and recommendations for use of specific positioning aids to promote musculoskeletal development, prevent contractures and promote cranial molding/brain development, and facilitate optimal quiet alert and sleep states.

Ongoing assessment of non**Nutritive oral motor development and effectiveness via bottle by recommending nipple/bottle style, positioning, external oral support and pacing, and assisting with respiratory coordination.**

c. **Non** nutritive oral motor development and effectiveness in relation to adjusted age. Recommend**assessment by recommending** appropriate pacifier and positioning to promote oral motor performance and endurance consistent with gestational age.

d. Ongoing assessment of nutritive oral motor development and effectiveness by bottle and/or breast in relation to adjusted age. Recommend nipple/bottle style, positioning, external oral support and pacing, assisting with respiratory coordination, necessary for safe feeding. Recommend oral feeding frequency to promote efficient feeding skills, prevent fatigue and weight loss, and improve quality and consistency of feeding experience for nursing staff, caregiver and infant.

e. Ongoing assessment of sensory responses to stimuli including auditory, visual, tactile, vestibular and proprioceptive in relation to adjusted age/medical status to promote progressively more mature sensory integration and responses.

f. Continuing assessment of state regulation as related to infant's ability to achieve and maintain a variety of alert states and promote increased endurance for handling/social interaction typical of their developmental age.

g. Performance of the following standardized tests when appropriate for infants:

i. Neurological assessment of pre-term and full-term infants: consists of 6 behavioral states, 9 neurobehavioral states, 6 reflexes, 16 muscle tone and movement items.

ii. Test of Infant Motor Performance (TIMP) or Gross Motor Assessment (GMA): 34 weeks-4 months corrected. Posture and movement assessment, spontaneous and elicited.

iii. N-PASS: Pain assessment scale.

iv. Early Feeding Skills Assessment (EFS): assesses readiness, physiological and behavioral states, oral-motor coordination, swallowing coordination, and state following feedings.

v. Breast-feeding and Bottle-feeding assessment.

h. Participate with Nursing and Lactation consultants in Kangaroo Care and breastfeeding process to promote development of baby's oral-motor skills, state regulation and parent/infant interaction through positioning and assessment of sensory responses.

i. Participate in weekly multidisciplinary discharge meeting to provide update on developmental status and needs, progress with parent/caregiver teaching, and discuss follow-up needs. Will help coordinate discharge follow up recommendations.

j. Participate in multidisciplinary family conferences as needed to discuss feeding, development and neuromuscular issues and follow-up needs in NICU and post-discharge.

k. Orthotic Fabrication/casting/taping for neuromuscular problems and contracture management**Grand Rounds as an optional member when appropriate,** per physician order**CCS guidelines**.

l. Participate in Modified Barium Swallow Studies, as appropriate.

2. **The primary role of** Occupational Therapy (OT)/Physical Therapy (PT) Roles and Responsibilities:

~~a. Infant positioning~~
~~b. Infant feeding~~

~~3. Speech Therapy (ST)/OT Roles and Responsibilities~~
~~a. Assess swallowing function in conjunction with Radiology (Video Fluoroscopy Swallow Studies/Modified Barium Swallow Studies/Fiber Optic Endoscopic Evaluation of Swallow to include dual discipline attendance) to.~~
~~b. Ongoing parent and staff teaching regarding developmental level, feeding deficits and skills (breast, bottle and non-nutritive suck), neuromuscular and orthopedic status, positioning needs and sensory issues.~~
~~c. As needed, parent teaching in car seat safety and adaptive positioning, per American Academy of Pediatrics and per Standardized National Highway Traffic Safety Administration curriculum.~~
~~d. Provide treatment plans to appropriate staff to communicate oral motor, feeding, positioning, and sensory recommendations with other team members.~~
~~e. Maintain a NICU role delineation document which specifies provision of care by discipline.~~

~~4. Infection Control~~
~~a. Follows Unit specific infection control procedures (Department/Patient Care Manual) to include initial hand washing prior to treatment, post-treatment, and between patients, and adheres to Tri-City Medical Center's general policies regarding blood-borne pathogens and infection control.~~

~~5. All personnel assigned to the NICU must follow these requirements:~~
~~a. Any article of therapist's clothing should be changed prior to treating a patient if it becomes:~~
~~i. Noticeably soiled~~
~~ii. Substantially wet~~
~~iii. Contaminated by bodily fluids or secretions~~
~~b. Specific to NICU: any employee demonstrating the following symptoms~~ **~~in the NICU~~** ~~will not provide direct patient contact and must check with Employee Health~~ **~~pertain to feeding and neurobehavioral development with secondary emphasis on musculoskeletal dysfunctions.~~**
~~i. Sore throat~~
~~ii. Eye drainage~~
~~iii. Herpes virus infection~~
~~iv. Vomiting~~
~~v. Runny nose~~
~~vi. Fever~~
~~c. Safety & Quality~~
~~i. Follows NICU and Rehabilitation Services unit-specific Department Safety Policies and Procedures.~~
~~ii. Performs all procedures per Policies and Procedures and specific protocols responding to patient needs in a timely manner.~~
~~iii. Provides education for family and other caregivers and staff regarding developmental level, neuromuscular/orthopedic status, oral motor/feeding skills, sensory integration, positioning, Kangaroo Care/breast feeding, home program activities and referrals for community and outpatient services, as indicated.~~
~~iv. Participates in NICU task force and/or PI activities as needed, per Tri-City Medical Center Performance Improvement Plan care in NICU setting.~~
~~v. Engages in professional communication, with customer service emphasis in all interactions with parents and staff.~~
~~**Discharge planning recommendations (i.e. DME, HEP, outpatient follow-up) should be included as part of all documentation.**~~

~~**Physical Therapy:**~~

- **~~In accordance with the American Physical Therapy Association *Neonatal Physical Therapy. Part I Clinical Competencies and Neonatal Intensive Care Unit Clinical Training Models and Neonatal Physical Therapy. Part II: Practice Frameworks and Evidence-Based Practice Guidelines~~:**
  - **~~"Neonatal practice is a highly specialized area within pediatric physical therapy in which vulnerable infants with complex medical, physiological, and behavioral conditions may inadvertently be harmed through examination and intervention procedures. The NICU is not an appropriate setting for PT assistants, PT generalists, and PT students."~~**
  - **~~"Pediatric PTs need expanded training in many areas including family systems, NICU environment, collaborative team work in a critical care unit, infant development, brain development, physiological evaluation and monitoring, and infant neurobehavioral functioning."~~**

d. ~~Qualifications:~~

i. ~~Must be licensed as a PT, OT or SLP by State of~~ **Valid and current** ~~California~~ **licensure in Physical Therapy**

ii. ~~Must maintain an active CPR card.~~

iii. ~~Complete the required unit-specific training by NICU Coordinator or appointed preceptor.~~

iv. ~~Completion of 2 years therapy experience with NICU/PICU specific population.~~

v. ~~Completion of continuing education specific to developmental care of the high-risk NICU infant, including mentoring and academic study.~~

vi. ~~Demonstration of unit competency based on completion of orientation and continued proficiency as determined by annual peer review.~~

- **~~Adherence to all standards as outlined by the American Occupational Therapy Association *Specialized Knowledge and Skills for Occupational Therapy Practice in the Neonatal Intensive Care Unit*~~**
- **~~For independent practice:~~**
  - **~~Completion of application with California Children's Services (CCS) to be a paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.~~**
  - **~~Have the Certified Neonatal Therapist (CNT) designation or be CNT eligible~~**
- **~~For licensed clinicians who do not have the above qualifications for independent practice and require supervision:~~**
  - ~~Completion of application with California Children's Services~~ **~~(CCS)~~** ~~to be a CCS-paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.~~
  - **~~Demonstrate proficiency in evidence based practice in both didactic theory and daily practice through department specific mentorship program documentation and~~**
  - **~~Documentation of services provided requires co-signature from a licensed clinician who meets the criteria for independent practice~~**

- **~~Initiation of Physical Therapy services will occur under the following conditions:~~**
  - **~~Patient medically cleared and stable to start services, including but not limited to:~~**
    - **~~Patient off ventilator or respiratory assistance~~**
    - **~~Patient discontinued from central lines (i.e. UAC, UVC, PICC)~~**
    - **~~Patient greater than 26 weeks estimated gestational age at birth (EGA)~~**
  - **~~With valid, individualized, specific and timely orders from the referring physician~~**

- After assessment by attending physician who has identified impairments or potential impairments in one of the below areas
- After failed attempts by nursing to address said impairments or potential impairments
- Provision of consultative evaluation and intervention include the following areas:
  - Central nervous system and musculoskeletal system
  - Behavioral state regulation and behavioral stress cues
  - Motor and sensory motor skills
  - Social development and infant/parent interaction
  - Early cognitive development and learning opportunities in infancy
- Participate in multidisciplinary rounds and family conferences as an optional member, when appropriate, per CCS guidelines.
- Must demonstrate ongoing competency in both ongoing continuing education courses specific to the NICU and through peer review.
- The primary role of Physical Therapy in the NICU will pertain to musculoskeletal dysfunctions with secondary emphasis on feeding and neurobehavioral development.
- Discharge planning recommendations (i.e. DME, HEP, outpatient follow-up) should be included as part of all documentation.

Speech Language Pathology:

- In accordance with the American Speech-Language-Hearing Association *Knowledge and Skills Needed by Speech-Language Pathologists Providing Services to Infants and Families in the NICU Environment*
  - "Recognizing the significant impact of development of communication, cognition, feeding, and swallowing in the developing infant, it is essential that speech-language pathologists possess the knowledge and skills to be proficient in the delivery of team based services to preterm and medically compromised infants and their families."
- Qualifications:
  - Valid and current California licensure in Speech Language Pathology
  - Adherence to all standards as outlined by the American Speech-Language-Hearing Association *Knowledge and Skills Needed by Speech-Language Pathologists Providing Services to Infants and Families in the NICU Environment* For independent practice:
    - Completion of application with California Children's Services (CCS) to be a paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.
    - Have the Certified Neonatal Therapist (CNT) designation or be CNT eligible
  - For licensed clinicians who do not have the above qualifications for independent practice and require supervision:
    - Completion of application with California Children's Services (CCS) to be a paneled provider working with infants and children aged 0-21 years that have CCS-eligible conditions.
    - Demonstrate proficiency in evidence based practice in both didactic theory and daily practice through department specific mentorship program documentation and
    - Documentation of services provided requires co-signature from a licensed clinician who meets the criteria for independent practice
- Initiation of Speech Language Pathology services will occur under the following conditions:
  - Patient medically cleared and stable to start services, including but not limited to:

- ~~Patient off ventilator or respiratory assistance~~
- ~~Patient discontinued from central lines (i.e. UAC, UVC, PICC)~~
- ~~Patient greater than 26 weeks estimated gestational age at birth (EGA)~~

~~With valid, individualized, specific and timely orders from the referring physician~~

~~After assessment by attending physician who has identified impairments or potential impairments in one of the below areas~~

~~After failed attempts by nursing to address said impairments or potential impairments~~

~~Provision of consultative evaluation and intervention include the following areas:~~

~~Swallowing: Completion and interpretation of instrumental swallow evaluation (i.e Modified Barium Swallow Study) when ordered by the physician for assessment of dysphagia and aspiration risk~~

~~Behavioral state regulation and behavioral stress cues in relation to pre-verbal skills and communication development~~

~~Social development and infant/parent interaction~~

~~Early cognitive development and psychobiology of early learning in the neonate~~

~~Participate in multidisciplinary rounds and family conferences as an optional member, when appropriate, per CCS guidelines.~~

~~Must demonstrate ongoing competency in both ongoing continuing education courses specific to the NICU and through peer review.~~

~~The primary role of Speech Language Pathology in the NICU will pertain to dysphagia with secondary emphasis on feeding and neurobehavioral development.~~

~~Discharge planning recommendations (i.e. diet recommendations, compensatory strategies) should be included as part of all documentation.~~

~~Reference List~~

~~American Journal of Occupational Therapy, August 2018, Vol. 72: Occupational Therapy's Role in the Neonatal Intensive Care Unit~~

~~American Journal of Occupational Therapy, November/December 2006, Vol. 60, 659-668. Specialized Knowledge and Skills for Occupational Therapy Practice in the Neonatal Intensive Care Unit~~

~~Neonatal Physical Therapy. Part I: Clinical Competencies and Neonatal Intensive Care Unit Clinical Training Models. Sweeney JK, Heriza CB, Blanchard Y. Pediatric Phys Ther. 21(4)296-307.~~

~~Neonatal Physical Therapy. Part II: Practice Frameworks and Evidence-Based Practice Guidelines. Sweeney JK, Heriza CB, Blanchard Y, Dusing S. Pediatric Phys Ther. 22(1)2-16.~~

~~American Speech-Language-Hearing Association. (2004). Knowledge and skills needed by speech-language pathologists providing services to infants and families in the nicu environment [Knowledge and Skills]. Available from www.asha.org/policy.~~

~~vii.~~

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 07/09 **SUBJECT: Anesthesia Equipment**

REVISION DATE~~(S)~~: 01/13, 04/20

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~02/24
Administration Approval:	~~04/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
1. To provide guidelines for the cleaning and Preventative Maintenance (PM) of anesthesia equipment located in Surgical Services and other departments in which anesthesia services are provided (including, but not limited to, Emergency Department, Interventional Radiology, Cath Lab and PACU).

B. **DEFINITION(S)**
1. Critical Equipment: Devices that enter sterile tissue or the vascular system; must be processed by sterilization.
2. Semicritical Equipment: Devices or items that contact mucous membranes or non-intact skin; must be processed by sterilization, or, at a minimum, high-level disinfection.
3. Noncritical Equipment: Devices or items that come into contact with only intact skin. Intermediate-level or low-level disinfectants may be used to process noncritical items at the point of use.

C. **POLICY:**
1. Anesthesia equipment shall be cleaned according to manufacturer's instructions for use (IFU). Cleaning procedures shall follow all perioperative and infection control policies and procedures for Universal Precautions.
2. All disinfectants utilized to clean anesthesia equipment shall be hospital approved.
3. Biomedical Engineering (Biomed) department is responsible for the PM and service of all anesthesia equipment, per manufacturer's IFU. PM and service records are maintained in the Biomed department.
4. Anesthesia machine safety:
   a. Daily testing of anesthesia machines is performed by the anesthesia technician per manufacturer's IFU. Documentation of anesthesia machine daily testing is performed by the anesthesia technician and records are maintained in the Surgery Department for 3 years.
   b. Gas Scavenger: All anesthesia waste gases are vented through the hospital vacuum system that pumps exhaust to the atmosphere. Trace gas analysis is done on an annual basis by a contract service as part of medical gas testing, per Building Engineering department.
   c. Pin Index:
      i. All cylindered gases have specific pin connection system, to avoid interchanges.

ii. The cylindered gases with PIN index system are Oxygen, Nitrous Oxide, and Compressed Air.

d. Portable Cylinders:
   i. Portable cylinders may be stored together, but never with flammable gases or liquids.
   ii. Do not allow oil, grease, or flammable materials to come into contact with oxygen equipment, such as valves, regulators, fittings or gauges.
   iii. Oxygen cylinders should not be draped with any combustible materials.
   iv. All cylinders must be adequately secured to protect against accidental falls.

e. Vaporizers:
   i. Only the anesthesia technician or anesthesiologist is permitted to fill vaporizers.
   ii. The vaporizer safety lock-out system is used.

f. Medical gas hoses and adapters are color-coded.

D. **PROCEDURE:**

1. Cleaning of anesthesia equipment after each use:
   a. Don appropriate personal protective equipment (PPE).
   b. Discard trash, sharps, and linen into appropriate containers.
   c. Cover used critical and semicritical reusable equipment for transport to the dirty utility area. Reusable critical and semicritical anesthesia equipment includes, but is not limited to: bronchoscopes, Glide Scope handles and Glide Scope stylets.
   d. Clean and disinfect reusable noncritical equipment with a hospital-approved disinfectant according to manufacturer's instructions for use (IFU). Clean all surfaces of the anesthesia machine, monitors and carts with a hospital-approved disinfectant, according to manufacturer's IFU.
   e. Restock the machine and cart as necessary.

E. **REFERENCE(S):**

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

SURGICAL SERVICES
SURGERY

ISSUE DATE: 3/08 **SUBJECT:** Block Time

REVISION DATE(S): 6/09, 11/09, 4/15, 11/15, 02/17, 05/20

Department Approval:	~~03/20~~08/24
Operating Room Committee Approval:	~~03/20~~02/24
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~02/24
Administration Approval:	~~05/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**

1. To outline the granting, review, use and revocation of block time. Block time scheduling will be provided in the operating room to regulate and ensure continuity of scheduling and to optimize the utilization of the operating room.

B. **DEFINITIONS:**

1. **Block Time:** Surgical time consistently reserved for a surgeon, surgeon group or specialty.
2. **Full Block:** Eight (8) hours of time.
3. **Half Block:** Four (4) hours of time.
4. **Release Time:** Specified lead time prior to the day of the block which is a cutoff date or time.
   a. If the block is not booked by this time, the time will become available for open booking.
   b. If the surgeon voluntarily releases the block prior to the specified release date, the time will not be included when the adjusted utilization is calculated.
   c. If the block is not released prior to the specified lead time, the unused time is included in the adjusted utilization.
5. **Utilization:** The amount of time used for surgical cases.
6. **Utilization calculation:** The amount of time used for surgical cases divided by the amount of time allocated to the block.
7. **Adjusted Utilization:** Utilization calculated with released time subtracted from the allocated time.

C. **POLICY:**

1. Requested/Approval of Block Time:
   a. Surgeon, service or group may request time.
   b. Hospital administration may request time on behalf of a new surgeon or service.
   c. Block time will be granted based on actual/anticipated case volume.
   d. Requests will be approved by the OR Committee.
2. Release Time: Release time may vary among individual block and percentage released, depending upon utilization and type of service.
   a. For utilization of 85% or greater for a three-month period: 24 hour release (except in cases where 25% of the block time is released).
   b. For utilization of 70-84%: 72 hour release.
   c. For utilization at or below 69%: 7 day release.

d. Robotic block times are released two (2) weeks in advance.
e. Released block time cannot be reclaimed once released if other cases are scheduled during the time.
f. Released block time can be reclaimed if no cases are scheduled in the time.
g. If the block time is voluntarily released before the assigned release time, the released time does not count in the adjusted utilization calculation.
h. If the block time is not voluntarily released before the automatic release time, the unused time will be included in the adjusted utilization.
i. Adjustments to release times will be made quarterly (January, April, July, October) based on the prior quarter's utilization.

3. Maintenance of Block Time:
   a. Monthly block time utilization reports will be distributed to individual surgeons.
   b. Monthly block time utilization reports will be reviewed at OR Committee.
   c. Quarterly (January, April, July, and October) block utilization will be reviewed and the block time may be increased, reduced or revoked based on the prior six-month average.
   d. Block utilization must be at 60% adjusted or 50% unadjusted to retain block time.
   e. If utilization for the previous quarter falls below requirements, the surgeon/surgeon group/service will be notified of the deficiency.
   f. Periodic reviews of block time and surgeon on time arrival by the OR Committee may result in further adjustments to or reinstatement of block time.
   g. Generally, action is taken based on a rolling six-month average, NOT by per month average.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 6/09 **SUBJECT: Bumping Surgery Procedures**

REVISION DATE(S): 11/10, 09/12, 4/15, 02/17, 04/20

Surgical Services Department Approval:	**~~02/20~~08/23**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~02/20~~02/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~02/24**
Administration Approval:	**~~04/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**
1. To provide guidelines for "bumping" of a surgical procedure

B. **DEFINITIONS:**
1. **Bumping:** The process of superceding a scheduled case with an emergency/emergent/urgent procedure
2. **Emergency Surgical Procedure:** Any procedure requiring surgical intervention immediately upon presentation to preserve life or limb. Emergency procedures are performed in the first available operating room, or may require staffing an additional operating room (OR) immediately to care for the patient (i.e., trauma).
3. **Emergent Surgical Procedure:** Any procedure requiring surgical intervention within approximately one hour of presentation. Emergent procedures are performed in the first available time in the OR schedule.
4. **Urgent Surgical Procedure:** Any procedure which requires surgical intervention within approximately 4-6 hours of presentation. Urgent procedures are placed in an available time on the OR schedule.

C. **POLICY:**
1. Emergency/emergent procedures will take priority and will be performed before a scheduled procedure that is not in progress. The OR Supervisor/designee and Charge Anesthesiologist will advise the bumping surgeon of the affected surgeon to be contacted, based on the criteria listed below.
2. When a surgeon deems to bump another surgical procedure, the bumping surgeon must inform the affected surgeon of their intent.
3. The surgical case to be bumped will be determined by the OR Supervisor/designee and Anesthesiologist based on the following criteria:
   a. Time of case
   b. Length of case
   c. Condition of patient
   d. Availability of equipment
   e. Least disruptive to entire schedule
   f. Date/time the case was scheduled (last scheduled may be bumped first)
   g. Choosing of surgeons within the same group will not be a determining factor
4. Urgent procedures may require surgical intervention within a specific time period and may require a scheduled procedure to be bumped.

5. Every effort will be made to accommodate the bumped procedure in a timely manner, and the bumped procedure will take first priority for any open time.
6. When a surgeon elects to bump his/her own elective scheduled case, the bumped case will be placed in the order to be rescheduled based on availability of rooms and staff to accommodate the case.
7. Disagreement between surgeons in the above process will be arbitrated by the OR Medical Director, Chief of Surgery or Chief of Staff.
8. Requests for bumping may be referred to the appropriate surgical division for review.

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SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: CPR in Surgical Services**

REVISION DATE(S): 02/05; 07/09; ; 01/13

Department Approval:	~~02/20~~08/23
Operating Room Committee Approval:	~~03/20~~02/24
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
~~**Medical Executive Committee Approval:**~~	~~04/20~~24
Administration Approval:	~~05/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **DEFINITION(S):**
1. Surgical Services: Includes Pre-Operative Hold (POH), Progressive Care Unit (PCU) POH, Surgery, Endoscopy, and Post Anesthesia Care Unit (PACU).

B. **POLICY:**
1. Code Blue resuscitation efforts will be implemented on any patient suffering cardiac and/or respiratory arrest in the surgical suite, as appropriate to patient's code status.
2. A Crash Cart is available for use at all times in Surgery, POH, PCU-POH, and PACU. Crash Carts in Surgical Services are maintained per Patient Care Services (PCS) Policy: Emergency Carts.
3. Emergency cardiopulmonary resuscitation
   a. Surgery:
      i. The anesthesiologist will indicate when a patient is in a state of cardiac and/or respiratory arrest and will direct resuscitative efforts.
      ii. The surgeon, assistant or other personnel trained in BLS will initiate chest compressions per the anesthesiologist's direction.
      iii. The circulating nurse or designee will call for additional help as needed (call the Supervisor/designee to recruit additional help STAT, or overhead page the need for additional help, as applicable), note the time of the code begins, and assist the anesthesiologist as necessary.
      iv. Personnel responding to the code will bring the crash cart (including defibrillator) to the room.
      v. The circulating nurse or another member of the nursing staff will be designated to record the events on the "Code Blue Record" and record details of the event in the patient's Electronic Health Record (EHR).
      vi. Scrubbed personnel will maintain the sterile field and supplies as the situation warrants.
      vii. Additional available staff members shall remain outside the room (but still within close proximity) to perform duties as assigned.
      viii. A hospital-wide "Code-Blue" page may be initiated when necessary, at the discretion of the anesthesiologist and circulating RN.
   b. POH:
      i. Initiate a hospital-wide "Code Blue" page.
   c. PCU-POH:
      i. Initiate a hospital-wide "Code Blue" page.

d. PACU:
   i. Initiate a hospital-wide "Code Blue" page.
e. Endoscopy (OR 12):
   i. Initiate a hospital-wide "Code Blue" page.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 07/09 **SUBJECT:** Food and Drink, Surgery

REVISION DATE(S): 11/12, 01/13

Surgical Services Department Approval:	~~02/20~~07/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~02/24
Administration Approval:	~~04/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
1. To provide guidelines for the consumption of food and drink in surgical areas.

B. **DEFINITION(S):**
1. Restricted areas: Areas which are accessible only from semi-restricted areas. Wearing of surgical attire is required and masks are required in the presence of open sterile supplies or scrubbed personnel. Restricted areas include the Operating Rooms (OR's) and sub-sterile rooms.
2. Semi-restricted areas: Areas which are accessible from unrestricted, other semi-restricted, or restricted areas. Wearing of surgical attire is required. Semi-restricted areas include corridors leading to the Operating Rooms, sterile storage rooms, Anesthesia workroom, peripheral support areas, and processing areas.
3. Unrestricted areas: Areas which are accessible from the exterior of the building, other unrestricted areas or semi-restricted areas. Wearing of surgical attire is not required. Unrestricted areas include Pre-Op Hold, PACU, OR desk, offices, and hallways leading to these areas.

C. **POLICY:**
1. Food and drink must not be taken into the semi-restricted or restricted areas of the perioperative suite.
2. Food and drink must not be kept in refrigerators, freezers, cabinets, or on shelves, countertops, or workspaces where blood or other potentially infectious materials are present.

D. **REFERENCE(S):**

1. **Kyle, Erin DNP, RN, CNOR, NEA-BC,** ~~AORN, Inc. (2020).~~ **AORN** *Guidelines for Perioperative Practice*: **Transmission Based Precautions,** ~~.~~ Denver, **CO., 2023, pgs. 1204-1205.**~~.~~
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
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SURGICAL SERVICES
SURGERY

ISSUE DATE: 10/11 **SUBJECT: Hysteroscopy**

REVISION DATE(S): 01/13

Department Approval:	**~~02/20~~08/23**
Operating Room Committee Approval:	**~~03/20~~02/24**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~02/24**
Administration Approval:	**~~05/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
1. To outline fluid selection, fluid management parameters, and patient safety considerations in hysteroscopic procedures. .

B. **DEFINITION(S):**
1. Diagnostic hysteroscopy: Endoscopic visualization of the uterine cavity and tubal orifices to aid in the diagnosis of intra-uterine disease.
2. Operative hysteroscopy: Endoscopic visualization of the uterine cavity and tubal orifices and treatment of intrauterine disease.
3. Fluid deficit: The amount of fluid retained through extravasation during a hysteroscopic procedure. The fluid deficit is the amount of distending fluid infused during the procedure minus the amount of fluid recovered either by manual measurement or by measurement by the hysteroscopy fluid management system.

C. **POLICY:**
1. Antibiotic prophylaxis is not recommended for routine hysteroscopic procedures.
2. A fluid management system shall be used for all hysteroscopies.
3. Fluid selection:
   a. 0.9% Sodium Chloride is the fluid media of choice for diagnostic hysteroscopy and in operative cases where mechanical, laser, or bipolar energy is used. Monopolar electrosurgery is contraindicated with 0.9% Sodium Chloride.
      i. At fluid deficit of 1500mL, consider completing the procedure.
      ii. At fluid deficit of 2500mL, conclude the procedure immediately.
4. Patients undergoing hysteroscopy procedure will be monitored for fluid deficit to prevent fluid overload.
   a. Monitor the amount of fluid dispensed and collected during the procedure.
   b. The fluid management pump displays fluid inflow volume (the total volume that goes into the patient) and the fluid deficit (the volume that is missing from the scale).
   c. The hysteroscopy pump automatically tracks fluid deficit throughout the case, measuring and updating the fluid deficit display every 30 seconds.
   d. The "Deficit alert icon" on the pump alarms when the fluid deficit increases dramatically in a short time (greater than or equal to 300mL/minute).
   e. The hysteroscopy pump is programmed with a deficit threshold of 500mL. When this fluid deficit is reached, the pump will sound an alarm and the deficit value will blink continuously.

f. After each additional 100mL over the selected threshold, three warning tones will sound and the deficit display will blink.

g. The circulating nurse shall monitor the fluid inflow volume and fluid deficit throughout the case and notify the surgeon and Anesthesiologist when the fluid deficit reaches 500mL, and every 100mL thereafter.

5. An air embolism can result from air contained in the tube set or connected instrument reaching the patient. To prevent air embolism:
   a. Properly prime the tubing and instrument before use, per manufacturer's instructions for use (IFU).
   b. Do not allow irrigation bags to run dry.
6. Follow manufacturer's IFU for hysteroscopy pump set-up and operation.
7. Monitor the patient for physiologic changes, including core temperature, laboratory test results (e.g., electrolytes, coagulation studies) and potential fluid retention in the abdomen, face, and neck.

D. DOCUMENTATIONS:

1. Document the following in the Perioperative Record:
   a. Type of irrigation fluid used
   b. Fluid deficit (in mL).

E. REFERENCES:

1. The Use of Hysteroscopy for the Diagnosis and Treatment of Intrauterine Pathology. ACOG Committee Opinion No. 800. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135:e138-48.
2. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Operating Room (OR) Committee**

REVISION DATE~~(S)~~: 1/05, 6/09, 10/12, 5/15; 11/15, 02/17

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~02/24
Administration Approval:	~~04/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **OPERATING ROOM COMMITTEE:**
   1. Existence
      a. The chairperson of the Operating Room Committee will be either the chief of surgery or chief of anesthesia, alternating each fiscal year.
      b. Members shall consist of physician representation from anesthesia, surgical sub-specialties, perioperative nursing leadership and administration.
      c. The committee shall function as a liaison between Perioperative Services and the Medical Staff and shall:
         i. Conduct periodic review of operational policies (i.e., scheduling of elective and emergency cases)
         ii. Review incidents and adverse events
         iii. Review problems with the daily management of the Operating Room schedule
         iv. Review block time utilization
         v. Review late surgeons for appropriate sanctions
      d. The committee shall meet monthly in addition to any meetings called by the committee chair.
      e. The chair of the committee, with input from the Director of Surgical Services/designee and OR Medical Director, develops the meeting -agenda.
      f. Documentation of the minutes is forwarded to the Medical Staff Office and approved by the Medical Executive Committee and Board of Directors.
   2. Responsibility
      a. All surgical and anesthesia services are coordinated by the Operating Room Committee through the development of policies and protocols relating to the functioning of Pre-Operative Education (POE), Pre-Operative Hold (POH), Operating Room, Post-Anesthesia Care Unit (PACU), and Anesthesia Department. These are coordinated in conjunction with administration and are reviewed at least every three years.
      b. The Committee determines OR availability requirements to meet the needs of the community.

B. **EXTERNAL COMMITTEES:**
   1. Perioperative Services is represented on select hospital level committees in order to align surgical/anesthesia activities with other hospital-wide initiatives.

2. Members of the Perioperative Leadership team will represent Surgical Services on clinical product selection committees, patient safety committees, and regulatory compliance committees, as well as the following interdisciplinary committees, including, but not limited to:
   a. Infection Control Committee
   b. Quality Assurance (QA)/Performance Improvement (PI) Committee
   c. Policy and Procedure review committees (i.e., Clinical Policies and Procedure [CPP], Administrative Policies and Procedures [APP])
   d. Code Blue Committee
   e. Radiation Safety Committee
   f. Donor Committee

Tri-City Medical Center
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SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: **Patient Transport in the Perioperative Environment**

REVISION DATE~~(S)~~: 08/97~~;~~, 04/00~~;~~, 07/11~~;~~, 11/12, 01/13, 04/20

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~02/24
Administration Approval:	~~04/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**
   1. To outline the process of patient transport in the perioperative environment.

B. **POLICY:**
   1. Pre-Operative Hold (POH) Registered Nurse (RN), Surgery Supervisor, or other designated RN will call the nursing unit prior to transfer to receive a hand-off report from the patient's primary RN/designee and ensure patient's readiness for transport to the perioperative area.
      a. For ICU patients and critical/unstable patients, the perioperative nurse assigned to the case is to go to the unit and obtain bedside hand-off report from the primary RN prior to transporting the patient to Surgery. The anesthesiologist, anesthesia tech may assist with transport, as available. Intubated patients must be accompanied by the anesthesiologist during transport.
      b. Patients on a cardiac monitor must be transported with a transport monitor and RN, unless the physician writes an order for the patient to transport without monitoring.
   2. The following written information will be available to the transporting PeriOperative Aide:
      a. Patient's Name
      b. Room number
      c. Medical Record Number (MRN)
      d. Surgeon's name
      e. Name of patient's nurse on nursing unit
      f. Isolation precautions (yes/no, type if applicable)
      g. Restraints (yes/no, type if applicable)
      h. Falls risk (yes/no)
      i. Monitor/Nurse needed for transport (yes/no)
      j. Oxygen needs
      k. Mode of transport (i.e. bed or gurney)
      l. Location to bring patient (i.e. POH, PACU/Cubicle, X-ray Room #, Endoscopy, etc.)
   3. If transporting by gurney, obtain a clean gurney from the Pre-Op Hold area with a sheet, blanket, and pillow.
   4. Patients will be transported to Surgery in their bed at the discretion of the RN.
      a. Two transport personnel shall be used to transport a patient in their bed.
   5. Isolation precautions shall be followed during transport, when applicable.
   6. Upon arrival to the floor, notify the patient's nurse, obtain chart and proceed to patient's room.

a. Introduce self to patient.
b. Verify two patient identifiers by checking patient ID band with the chart and confirming with patient.
c. Ensure patient's privacy by drawing curtain and placing blanket over patient before pulling down bed linen.
d. Before transferring patient to gurney, ensure wheels on bed and gurney are locked.
e. A floor nurse or the lift team will assist with transferring patient to gurney (if required), making sure IV and drainage bags are carefully moved with the patient and IV bag is hung on IV pole on gurney. Urine drainage bags are to be hung on the bedframe below the level of the patient's bladder, avoiding dependent loops in the urinary drainage tubing.
f. Raise and secure side rails and make sure patient's arms and legs are inside rails.
g. Transporter shall stay at the head of the gurney.
h. Transport feet first, at an appropriate speed. Enter elevators head first.
i. Upon arrival to POH or the OR, appropriate personnel will be notified and chart given to the RN assigned to the patient. The transporter shall remain with the patient until the RN arrives to assume care of the patient.
j. Upon arrival to POH, lock the bed/gurney, place it in lowest position and ensure side rails are up. Give the patient the following items:
    i. Warm blanket
    ii. Hair cover
    iii. Call bell
    iv. Pulse oximeter placed on patient's finger
    v. Blood pressure cuff placed on bed

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SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/00 **SUBJECT: Perioperative Documentation**

REVISION DATE~~(S)~~:~~-02/02~~;, ~~02/06~~;, ~~11/12~~;, 08/15, 05/20

Department Approval:	**~~03/20~~08/23**
Operating Room Committee Approval:	**~~03/20~~02/24**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~02/24**
Administration Approval:	**~~05/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
   1. To establish guidelines for intraoperative nursing documentation.

B. **POLICY:**
   1. As part of the patient's legal health record, the perioperative patient healthcare record should reflect the plan of care, including patient assessment findings, nursing interventions performed, and patient outcomes.
   2. The electronic health record (EHR) should reflect continuous reassessment and evaluation of the perioperative nursing care and the patient's response to implemented nursing interventions.
   3. The components of clinical documentation shall include, but not be limited to the following elements, as applicable to each case:
      a. Assessments
      b. Clinical problems
      c. Communications with other health care professionals regarding the patient
      d. Communication with and education of the patient, patient's family members, and the patient's designated support person (as applicable)
      e. Medication records
      f. Order acknowledgement, implementation and management
      g. Patient care interventions
      h. Patient clinical parameters
      i. Patient responses and outcomes, including changes in the patient's status
      j. Plans of care that reflect the social and cultural framework of the patient
   4. Perioperative nursing documentation should correspond with established guidelines and practices for perioperative nursing care, health care accreditation organization requirements, Tri-City Medical policies and procedures, and local, state, and federal regulatory requirements.
   5. The names, roles, and credentials of all individuals participating in the patient's care, as well as observers in the procedure, must be recorded in the patient health care record.
   6. Applicable segments of the perioperative record shall be completed in the EHR for each procedure, including, but not limited to:
      a. Pre-Operative Checklist (including documentation of the Pre-Procedure Verification process)
      b. Case times
      c. Case attendees
      d. Skin assessment

e. Patient positioning
f. Procedural verification for all procedures performed in the case (i.e., Time Out)
g. Fire risk assessment
h. General case data, including location of the procedure, patient ASA score, wound classification, and pre-operative and post-operative diagnosis
i. Surgical procedure(s) and anesthesia type(s)
j. Skin preparation and hair removal
k. Counts, including outcomes of counts and follow-up actions for incorrect counts
l. Patient care devices
m. Laser information and laser safety measures
n. Cautery used, including settings, lot number and expiration date of return electrode, and skin assessment before and after return electrode placement
o. Tourniquet, including settings and skin assessment before and after tourniquet use
p. Catheters, drains and tubes
q. Medications administered on the sterile field
r. Irrigation fluids
s. Cell Saver (i.e., blood salvage system) information, including machine identification number, anticoagulant used, volume collected in the reservoir and volume returned to the patient, wash volume, hematocrit (QC) of the first processed bowl, and name of personnel reinfusing blood
t. All surgical specimens and cultures sent
u. Implants and prosthetics, including all identifiers as applicable
v. Dressings
w. OR departure information
x. Charges for supplies used during the procedure (i.e., Pick List)

7. Tissue implants shall be documented in the Carefusion Tissue and Implant Module (TIM) system, using the Carefusion TIM application icon located on each computer desktop in Surgery. Refer to Carefusion Pyxis Tissue and Implant Module User Guide for complete guidelines.

C. **REFERENCES**:

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09

SUBJECT: Perioperative Standards of Practice

REVISION DATE~~(S)~~: 11/12, 013/13, 04/20

Surgical Services Department Approval:	~~02/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~02/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/20~~02/24
Administration Approval:	~~04/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. To describe the responsibilities for which perioperative practitioners are accountable and to define a competent level of nursing practice and professional performance that is designed to achieve desired patient outcomes in the perioperative setting.

B. **POLICY:**

1. Structure standards were developed to guide professionals in administrative roles and to provide direction for evaluating operational systems.
   a. A philosophy, a purpose, and objectives shall be formulated to guide surgical care.
   b. An organizational plan for surgical care shall be developed and communicated.
   c. A registered nurse shall be authorized with administrative accountability and responsibility for surgical care.
   d. A registered nurse administrator shall be accountable and responsible for developing mechanisms that ensure optimal age-appropriate patient care.
   e. Surgical Services management team shall develop and manage the budget for surgical care.
   f. Surgical Services shall have written policies and procedures that serve as operational guidelines.
   g. Surgical Services management team shall be responsible for establishing staffing requirements, selecting personnel, and planning for the appropriate utilization of human resources.
   h. Staff development programs shall be provided for surgical care personnel.
   i. A safe surgical environment shall be established, controlled, and consistently monitored.
   j. Surgical Services leadership team shall promote the discovery and integration of new knowledge by encouraging development and use of nursing research.
   k. Surgical Services staff shall maintain appropriate documentation related to surgical activities.
   l. Surgical Services leadership team shall recognize professional responsibility to promote, provide, and participate in a learning environment for students in health care disciplines.
   m. Surgical Service shall establish methods for continuous assessment, measurement, and improvement in the quality of patient care and departmental functions, in conjunction with the organization's Quality Plan.
2. Standards of perioperative clinical practice focus on the process of providing nursing care that is population specific (i.e. culturally and age specific).
   a. The perioperative nurse collects patient health data.

b. The perioperative nurse analyzes the assessment data in determining diagnosis.
c. The perioperative nurse identifies expected outcomes unique to the patient.
d. The perioperative nurse develops a plan of care that prescribes interventions to attain the expected outcomes.
e. The perioperative nurse implements the interventions identified in the plan of care.
f. The perioperative nurse evaluates the patient's progress toward attainment of outcomes.

3. Standards of perioperative professional performance focus on the process of performing professional role activities.
   a. The perioperative nurse systematically evaluates the quality and appropriateness of nursing practice.
   b. The perioperative nurse evaluates his or her practice in the context with professional practice standards and relevant statutes and regulations.
   c. The perioperative nurse acquires and maintains current knowledge in nursing practice.
   d. The perioperative nurse contributes to the professional growth of peers, colleagues, and others.
   e. The perioperative nurse's decisions and actions on behalf of the patient are determined in an ethical manner.
   f. The perioperative nurse collaborates with the patient, significant others, healthcare providers, and others in providing care.
   g. The perioperative nurse uses research findings in practice.
   h. The perioperative nurse considers factors related to safety, effectiveness, efficiency, environmental concerns, and cost in planning and delivering patient care.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94 **SUBJECT: Positioning the Surgical Patient**

REVISION DATE(S): 01/96, 01/97, 04/97, 02/00, 03/03, 01/06, 09/07. 06/09. 01/13, 06/23, 05/20

Department Approval:	~~02/20~~07/23
Operating Room Committee Approval:	~~03/30~~02/24
Department of Anesthesiology Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~02/24
Administration Approval:	~~05/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**
1. To provide guidelines for positioning the patient undergoing operative or other procedures in the perioperative area.
2. The goals of patient positioning include:
   a. Providing exposure of the surgical site
   b. Maintaining the patient's comfort and privacy
   c. Providing access to intravenous (IV) lines and monitoring equipment
   d. Allowing for optimal ventilation by maintaining a patent airway and avoiding constriction or pressure on the chest or abdomen
   e. Maintaining circulation and protecting muscles, nerves, bony prominences, joints, skin, eyes, and vital organs from injury
   f. Observing and protecting fingers, toes and genitals
   g. Stabilizing the patient to prevent unintended shifting or movement

B. **POLICY:**
1. Provide care that respects the dignity and privacy of each patient during patient positioning.
2. Implement measures to provide privacy during patient positioning.
   a. Keep windows covered (as applicable) and doors closed in patient care areas
   b. Limit traffic in the procedure room
   c. Expose only the areas of the patient's body necessary to provide care or access
3. Conduct a preoperative patient assessment to identify patients at risk for positioning injury, develop a plan of care, and implement interventions to prevent injury.
4. Perform a preoperative assessment of factors related to the procedure that includes:
   a. Type of procedure
   b. Estimated length of the procedure
   c. Ability of the patient to tolerate the anticipated position
   d. Amount of surgical exposure required
   e. Ability of the anesthesia professional to access the patient
   f. Desired procedural position, potential change of position, and positioning devices required
   g. Critical devices (e.g., catheters, drains)
   h. Jewelry or body piercings
   i. Braided hair, hair accessories, or hair extensions (patients positioned on these are subject to injury).

j. Superficial implants (e.g., dermal) or implanted critical devices (e.g., pacemaker)
k. Prosthesis (e.g., prosthetic limb) or corrective devices

5. Perform a preoperative assessment of the patient's risk for pressure injury. The patient is considered high risk for pressure injury development in surgery if any of the following criteria are met:
   a. Surgical procedure duration greater than three (3) hours
   b. 70 years of age or greater
   c. Smoker
   d. Diabetes
   e. Vascular disease
   f. Vascular surgery
   g. Glaucoma
   h. Malnourished
   i. Morbidly obese
6. Implement protective measures to bony prominences if the patient meets one or more of the high risk criteria for pressure injury development in surgery.
   a. Offload pressure points (e.g., float heels off the bed by placing pillows beneath the legs).
   b. Place prophylactic dressings to bony prominences or other areas subjected to pressure, friction and shear (specific to each position).
7. Remove patient's jewelry, body piercings, hair accessories, or other items that may pose a risk for positioning injury before the patient is transferred to or positioned on the operating room bed.
8. Do not position the patient directly on critical or superficial implanted devices, to the extent possible.
9. Use OR beds, bed attachments, positioning equipment, positioning devices, and support surfaces according to manufacturer's instructions for use (IFU).
   a. Verify cleanliness, surface integrity, and correct function of positioning equipment, devices, and support surfaces before use.
   b. Remove soiled, damaged, or defective surfaces, devices, and equipment from service and have them cleaned, repaired, or replaced.
   c. Ensure all beds/gurneys and operative tables are locked before transferring the patient from one surface to another.
10. Ensure adequate number of personnel, devices, and equipment are available during patient positioning activities to promote patient and personnel safety.
11. At least one surgical team member should attend to the patient on the OR bed at all times.
12. Coordinate positioning of the patient with team members by verifying all team members are ready for positioning to occur and implementing a countdown to begin positioning.
13. When the patient has critical devices (i.e., catheters, drains, tubes) communicate about the presence of the critical device and take measures to secure the devices during and after positioning.
14. Position patients on surfaces that reduce the potential for pressure injury and ensure surfaces are smooth and wrinkle-free.
   a. Avoid positioning patients on multiple layers of blankets, sheets, or other materials.
   b. Avoid positioning patients on warming blankets.
15. Implement safe positioning practices, including, but not limited to:
   a. Assess and maintain the patient's physiologic alignment, including head and neck in a neutral position without extreme lateral rotation, during all phases of the procedure.
   b. The anesthesiologist shall protect the patient's eyes when the patient is under general anesthesia.
   c. Do not allow the patient's neck to be hyperextended for long periods of time.
   d. Prevent the patient's body from contacting metal portions of the OR bed and other hard surfaces.
   e. Prevent the patient's extremities from unintentionally dropping or hanging below the level of the OR bed.
   f. Monitor the location of the patient's hands, fingers, feet, toes, and genitals during positioning activities, including changes in configuration of the OR bed.

g. Apply safety restraints and monitoring devices (e.g., blood pressure cuffs, pulse oximetry sensors) in a manner that safely secures the patient and allows the accessory device to function effectively without nerve, tissue or circulatory compromise.
   i. Verify placement, tightness, and security of safety restraints after positioning or repositioning activities.

h. Monitor the patient's position after positioning activities and during the procedure, and take corrective actions as indicated.
   i. Scrubbed personnel shall not lean against the patient.

i. Repositioning interventions may be implemented during the procedure as necessary.

j. Assess the patient's skin immediately post-operatively and document any interventions.

C. **PROCEDURE:**

1. For specific instructions on positioning the surgical patient and use of specialty frames, tables and positioning equipment, refer to Elsevier Online Skills on the Tri-City Medical Center intranet and equipment manufacturer's IFU.

D. **DOCUMENTATION:**

1. Document the following information in the patient's electronic health record (EHR):
   a. Pre-operative skin assessment and reassessment(s) as necessary for changes in skin integrity
   b. Patient's position, including position of the patient's arms and legs and any repositioning activities
   c. Personnel participating in positioning the patient
   d. Type and location of positioning equipment or devices
   e. Type and location of safety restraints
   f. Type and location of any additional padding provided
   g. Actions taken to prevent patient injury, especially any actions taken in response to findings from pre-operative assessment and location(s) of dressing(s) applied for pressure injury prevention
   h. Postoperative assessment

E. **REFERENCES:**

1. *Guidelines for Perioperative Practice, Positioning the Patient*, Association of Perioperative Registered Nurses (AORN), Denver (2023) pg. 702-750.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 04/94

SUBJECT: **Protective Barriers: Materials for Gowns and Drapes**

REVISION DATE~~(S)~~: 02/05~~;~~, 06/09; 11/12, 01/13, 04/20

Surgical Services Department Approval:	**~~02/20~~08/23**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~02/20~~02/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~02/24**
Administration Approval:	**~~04/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**
1. To provide guidelines for the evaluation, selection, and use of protective barrier materials used as surgical gowns and drapes.

B. **POLICY:**
1. Surgical gowns and drapes shall be disposable and should be made of materials that minimize the passage of microorganism from non-sterile to sterile areas.
   a. Materials (including seams) shall be resistant to penetration by blood and other liquids
   b. Materials shall be resistant to tears, punctures, strain and abrasion.
   c. Manufacturers shall provide data concerning the ability of each material to prevent bacterial transfer in relation to time, pressure and strike through.
2. Gowns and drapes shall be safe and comfortable for use in the practice setting.
   a. Materials shall resist ignition and have a low rate of flame spread.
   b. Materials shall be as lint-free as possible.
   c. Materials shall be nonabrasive and free of toxic ingredients.
   d. Materials shall be non-glare and of a color that minimizes distortion from reflected light.
   e. Materials shall maintain integrity over the expected life as claimed by the manufacturer.
   f. Materials shall maintain an environment appropriate to body temperature.
   g. Materials shall allow freedom of movement.
3. Select the surgical gown by task and anticipated degree of exposure to blood, body fluids, or other potentially infectious materials, as determined by the following factors:
   a. Team member's role
   b. Type of procedure (e.g., minimally invasive versus open, superficial incision versus deep body cavity incision)
   c. Procedure duration
   d. Anticipated blood loss
   e. Anticipated volume of irrigation fluid
   f. Possibility of handling hazardous medications
   g. Anticipated patient contact (e.g., splash, soaking, leaning)
4. Select the surgical gown needed for the procedure according to the barrier performance class as stated on the product label.
5. Select and wear surgical gowns that wrap around the body and completely cover the wearer's back. The gown sleeves should conform to the shape of the wearer's arms, be of sufficient

length to allow gloves to completely cover the cuffs, and be of sufficient length to prevent the gown cuffs from being exposed when the wearer's arms are extended.

6. Scrubbed personnel may wear a surgical helmet system when splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and facial contamination can be reasonably anticipated.
7. Sterile drapes shall be used to establish a sterile field. Sterile drapes provide a barrier that minimizes the passage of microorganisms from unsterile to sterile areas.
8. Sterile drapes should be placed on the patient, furniture, and equipment in the sterile field in a manner that prevents contamination.
9. Sterile drapes should be handled as little as possible
10. In the draping process, the drape material should be held above waist level, in a compact position, draping from operative site to periphery. Sterile drapes should be placed in a manner that does not require scrubbed team members to lean across an unsterile area and that prevents the sterile gowns from contacting an unsterile area.
11. During draping, the gloved hands should be shielded by cuffing the interior portion of the drape material over the sterile gloves.
12. Once placed, sterile drapes should note be moved or shifted.
13. Surgical equipment (e.g., tubing, cables) should be secured to the sterile field with non-perforating devices.
14. Consider only the top surface of the sterile drape to be sterile. Consider items that fall below the level of the sterile field to be contaminated.

C. **REFERENCES:**

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 10/11

SUBJECT: Scope of Service for Surgical Services

REVISION DATE~~(S)~~: 12/11~~;~~, 10/12~~;~~, 5/15~~;~~, 02/17, 06/20

Department Approval:	~~03/20~~08/23
Department of Anesthesiology Approval:	n/a
Operating Room Committee Approval:	~~04/20~~02/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~02/24
Administration Approval:	~~06/20~~03/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **PURPOSE:**
1. To describe the Scope of Service for the department of Surgical Services at Tri-City Medical Center, including Pre-Operative Education (POE), Pre-Operative Hold (POH), Post Anesthesia Care Unit (PACU), Surgery, Endoscopy, and the Sterile Processing Department (SPD).

B. **POLICY:**
1. Goals
   a. To improve the general health and well-being of patients who require surgical care.
   b. To improve patients' health knowledge related to pre-operative preparation, the scheduled surgical procedure, and post-operative plan for patients requiring surgical care.
   c. To reduce and manage complications and unexpected outcomes.
   d. To continuously evaluate and improve the services provided.
2. Description of Service & Assessing Department Services
   a. The department of surgical services provides diagnostic, therapeutic and operative interventions for patients requiring a variety of surgical procedures 24 hours a day, 7 days a week.
   b. Assessment activities include pre-operative, intra-operative and post-operative patient care for persons requiring elective, urgent or emergent surgery.
   c. The Pre-Operative Education department provides instructions to patients electively scheduled for procedures regarding preparation for surgery, surgical procedures and post-operative care.
      i. POE facilitates ordered laboratory and diagnostic procedures as part of the pre-operative patient preparation, and gathers patient health history information.
      ii. POE appointments are conducted in-person or via telephone, Monday-Friday 8:00am-5:00pm.
   d. The Pre-Operative Hold department is responsible for assessing patients prior to surgery and carrying out pre-operative orders. POH is staffed with RN's Monday-Friday 5:30am-6:30 pm. After hours, the surgical RN is responsible for assessing patients pre-operatively and completing pre-operative orders.
   e. The PACU provides nursing care to patients requiring post anesthesia recovery from a variety of surgical, endoscopic, cardiac and interventional radiology procedures 24 hours a day, 7 days a week

f. SPD provides 24/7 support to Surgery by providing sterile instruments, supplies and equipment necessary to complete surgical procedures.

3. Methods Used To Assess Patient Needs
   a. Patient health history and educational needs related to the surgical procedure and post-operative care are assessed by a Pre-Operative Education Registered Nurse (RN) during the Pre-Operative Education appointment (as applicable).
   b. Pre-Operative patient assessment and care is performed by a Pre-Operative Hold (POH) Registered Nurse (RN).
   c. Post anesthesia patient assessment and care is performed by a PACU RN.
   d. Patients are assessed and prepared for surgery by a perioperative RN on the day of surgery.
   e. Patients are assessed by a surgical Registered Nurse (RN) and anesthesia care provider (if applicable) prior to transfer to the Operating Room (OR) or Endoscopy procedure room.
   f. Ongoing patient assessment and care is performed by the circulating RN and anesthesia care provider in the OR throughout the procedure. RN's may monitor patients and administer moderate sedation for appropriate procedures (including Endoscopy procedures), per Patient Care Services Policy: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures.
4. Scope of Services
   a. Service specialties include orthopedic, thoracic, vascular, neurosurgical, urologic, gynecological, anesthesia, plastics, otolaryngolic, ophthalmologic, oral surgery, endoscopic, cardiac, robotic and general surgery.
   b. There are 12 rooms in the OR suite, including 10 operating rooms (1-10) that can accommodate any type of case, a cystoscopy suite (OR 11) and an Endoscopy suite (OR 12).
   c. Patients are discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure, and admitted to the appropriate postoperative level of care.
   d. The POE department services electively scheduled outpatients and AM admissions for all surgical specialties.
   e. The POH department contains patient 16 bays. A Pre-Operative Hold and Phase II area with six (6) bays is available for elective admission of Progressive Care Unit patients and Phase II recovery. POH services inpatients, outpatients and AM admissions for all surgical specialties and Endoscopy.
   f. PACU is a sixteen bay unit, including two cubicles enabled to act as isolation rooms.
      i. Recovery services are provided to both inpatients and outpatients requiring post anesthesia recovery from a variety of surgical, endoscopic, cardiac and interventional radiology procedures
   g. Patients are discharged from the PACU and/or Phase II when discharge criteria are met. Patients may be discharged home or to the next appropriate level of care, per physician order.
5. Staffing
   a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the OR. On call and call-back will be utilized to additionally staff those shifts that have minimal staffing in-house.
   b. Each patient is assigned at least two surgical team members, one of which is the RN circulator.
   c. The Surgery Supervisor/designee will make staff assignments according to individual staff competencies and patient needs.
   d. Complex procedures requiring additional resources shall be staffed with additional personnel as appropriate.

e. For complete staffing and on-call guidelines see Surgical Services Policies Staffing, Admission/Discharge Criteria and On-call.
f. POE appointments are conducted by RN's. Appointments are scheduled in advance by the surgery schedulers.
g. Staffing for Pre-Operative Hold and the Post Anesthesia Care Unit is maintained in compliance with current American Society of Perianesthesia Nurses (ASPAN) Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements. On-call staff is available to cover the night shift and weekend
h. After hours, the surgical RN conducts the pre-operative patient assessment and preparation.

6. Patient Population
   a. Adult and geriatric patients requiring surgical management.
7. Extent to Which The Department's Level of Care/Service Meet Patient Needs
   a. The services provided by surgical services meet the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population.
8. Performance Improvement (PI)
   a. In order to improve patient care, several indicators are monitored and reported to the OR Committee, Infection Control Committee, Quality Committee or other committees as requested.
   b. PI data is posted in the department.
9. Standards of Practice
   a. Surgical Services follows practice recommendations as outlined in the Association of Perioperative Registered Nurses (AORN) Guidelines for Perioperative Practice
   b. POE, POH and PACU follows standards and practice recommendations as outlined in the American Society of PeriAnesthesia Nurses (ASPAN) Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements.
   c. The nursing service abides by regulations of California Title XXII, Joint Commission guidelines, CMS and the Board of Registered Nursing.
   d. See Surgical Services Policy Perioperative Standards of Practice
10. Medication Administration Standards Related to Care of The Patient
   a. Medications are dispensed via the Pyxis Medstation system. Emergency cardiac medications requiring refrigeration are stored in Cardiac OR locked refrigerator. The refrigerator temperature is monitored by Pharmacy.
   b. Anesthesia Pyxis Medstations are maintained in OR's 1-11.
   c. Preoperative antibiotics and medications dispensed to and/or administered on the surgical field during the surgical procedure are documented in the surgical nursing record.
   d. Anesthesiologists are responsible for documenting all medications they administer on the Anesthesia record.
   e. Medications administered in POH and PACU are documented in the electronic Medication Administration Record (eMAR) in the electronic health record (EHR).
   f. Medications in PACU shall be kept in wall-mounted lock boxes within each individual patient bay. Medications will be properly labeled and discarded/wasted before the patient is transferred/discharged from PACU. Medications shall not be left unattended outside a lock box.
   g. See Surgical Services Policy Medications in Surgery.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/09 **SUBJECT: Standard Precautions in Surgery**

REVISION DATE~~(S)~~: 11/12~~;~~, 07/15, 06/18, 04/20

Department Approval:	**~~02/20~~08/23**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**~~02/20~~02/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~02/24**
Administration Approval:	**~~04/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE**:
1. To identify those practices used by surgical personnel in addition to the hospital Standard Precautions policy, to protect both patients and personnel from exposure to bloodborne pathogens. The perioperative setting is a high-risk environment for exposure to bloodborne pathogens from percutaneous injuries due to the presence of large quantities of blood and other potentially infectious body fluids, prolonged exposure to open surgical sites, frequent handling of sharp instruments, and the requirement for coordination between team members while passing sharp surgical instruments.

B. **DEFINITIONS**:
1. Standard Precautions: The primary strategy for successful infection control and reduction of worker exposure. Precautions used for care of all patients regardless of their diagnosis or presumed infectious status.
2. Engineering Controls: Safety-engineered devices designed to prevent or reduce the incidence of worker injury and the risk of bloodborne pathogen exposure to the worker.
3. Neutral Zone: A work practice control technique used to ensure the surgeon and scrub person do not touch the same sharp instrument at the same time. This technique is accomplished by establishing a designated neutral zone on the sterile field and placing sharp items within the zone for transfer of the item between scrubbed personnel.
4. Perforation Indicator System: A double-gloving system comprising a colored pair of surgical gloves worn beneath a standard pair of surgical gloves. When a glove perforation occurs, moisture from the surgical field seeps through the perforation between the layers of gloves, allowing the site of perforation to be more easily seen.

C. **POLICY**:
1. Standard precautions shall be used when caring for all patients.
2. Blood and body fluids from all patients shall be considered infectious.
3. Protective barriers shall be made available to all personnel to reduce the risk of exposure.
4. Personal protective equipment (PPE) shall be worn whenever the possibility exists for exposure to blood, body fluids, or other potentially infectious materials. PPE shall depend upon the degree of exposure anticipated and may include:
   a. Goggles
   b. Glasses with side barriers
   c. Face shields
   d. Masks

e. Gowns (including impervious)
f. Shoe covers
g. Gloves

5. Remove PPE before leaving the work area and place used PPE in designated receptacle for disposal. Perform hand hygiene after PPE removal.
6. Eye protection shall be worn by all scrubbed personnel.
7. Scrubbed personnel should double glove (i.e., wear two pairs of sterile surgical gloves) and use a perforation indicator system.
8. Perioperative personnel shall take precautions to prevent injuries caused by scalpels and other sharp instruments.
   a. Perioperative personnel shall use engineering controls when feasible (i.e., sharps with engineered sharps injury protection), such as blunt needles, safety scalpels, safety needles and needeless systems.
   b. The "hands-free, Neutral Zone" technique shall be used when possible, to transfer sharps between personnel.
      i. Identify and designate the neutral zone before beginning the surgical procedure.
      ii. Use an instrument mat, magnetic pad, basin or designated area as the neutral zone.
      iii. Give verbal notification when a sharp is in the neutral zone.
      iv. Place one sharp at a time in the neutral zone.
      v. Orient the sharp for easy retrieval by the surgeon or fist assistant.
      vi. Ensure the sharp is handled by only one team member at a time.
      vii. Place sharp items in the neutral zone after use.
   c. Used needles shall not be sheared, bent, broken, or recapped by hand. If recapping is necessary, an instrument, or the one-handed scoop technique shall be used.
   d. Knife blades shall be loaded and removed using an instrument.
   e. Sharp devices must be contained, transported, and disposed of safely. Disposable sharps shall be placed in a puncture resistant, labeled, or color-coded leak proof container.
   f. The scrub person should account for and confine all sharps on the sterile field.
   g. Reusable sharps shall be placed in a puncture resistant container, isolated from other surgical instruments.
   h. Use gloves and an instrument to pick up sharp items that have fallen on the floor.
9. Standard Precautions shall be used when transferring specimens from the sterile field.
   a. All specimens shall be placed in a labeled container which prevents leakage during collection, handling, processing, storage, transport or shipping.
   b. Specimen containers received directly from the operative field shall be placed in a labeled leak- proof plastic bag or container.
10. Perioperative personnel shall control work practices to minimize the risk of exposure to bloodborne pathogens. This includes prohibition of eating, drinking, applying cosmetics, and handling of contact lenses in restricted and semi-restricted areas.
11. Perioperative personnel with dermatitis, infections, exudative lesions or non-intact skin shall refrain from providing direct patient care or handling of medical devices used in performing invasive procedures.
12. Perioperative personnel should be immunized against vaccine-preventable diseases.
13. Perioperative personnel shall adhere to Employee and Occupational Health Service (EOHS) policies regarding work restrictions for personnel with infectious diseases.
14. Infection control policies for Standard and Transmission based precautions shall be followed.
   a. Transport gurneys will be cleaned and fresh linen applied as soon as the patient is transferred to the operating table.
   b. Patient's isolation status shall be communicated during hand-off report.
   c. Patients on Airborne Precautions, including those with suspected or active pulmonary tuberculosis shall be recovered in a private cubicle with a portable high efficiency particulate air (HEPA) filter.

D. REFERENCES:

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 11/09

SUBJECT: Surgical Patients with implanted Electronic Devices

REVISION DATE~~(S)~~: 01/13, 05/20

Department Approval:	**~~02/20~~08/23**
Operating Room Committee Approval:	**~~03/20~~02/24**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~02/24**
Administration Approval:	**~~05/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
1. To outline the necessary steps in caring for a surgical patient with an implanted electronic device (IED).

B. **POLICY:**
1. Take precautions when the patient has any IED (e.g., gastric or cardiac pacemaker, implantable cardioverter defibrillator, cochlear implant, deep brain, vagal nerve, sacral nerve, phrenic nerve, spinal cord or bone stimulator).
   a. Electromagnetic interference (EMI) caused by energy-generating devices used during surgery can cause complications for the IED.
   b. Ensure surgeon and anesthesiologist are aware of patient's IED prior to surgery.
2. The team managing the implanted device should be consulted before surgery and as needed (e.g., implanting surgeon and/or device manufacturer).
3. Determine interventions to be performed for a patient with an existing IED based on the following information that may be obtained from patient assessment, patient caregivers, the device identification card carried by the patient, and the medical record:
   a. Type of implanted device
   b. Patient's level of dependence
   c. Location of the device and leads (e.g., within or outside the path between the active and dispersive electrodes)
   d. Device manufacturer and model
   e. Clinical indication for the device
   f. Battery life
   g. Device settings
   h. Lead placement
4. For cardiac devices, the following information is also needed:
   a. Date of last device interrogation or monitoring
   b. Lead polarity (i.e., unipolar or bipolar)
   c. Need for device programming
   d. Response of the device to a magnet
   e. Presence of an alert status on the generator or on the lead
   f. The last pacing threshold
5. Perform the following interventions for a patient with an existing cardiac implanted electronic device (CIED):

a. Reprogram the device by magnet or having equipment reprogrammed by a qualified person, if so advised by the team managing the CIED.
b. Place the dispersive electrode as close as possible to the surgical site, verifying the IED is not in the current pathway between the active and dispersive electrode.
c. Use electrocautery, bipolar forceps, or other alternative technology (e.g., ultrasonic technology).
d. Place the active electrode cord away from the pulse generator.
e. Use a five-lead ECG system.
f. Use a beat-to-beat indicator (e.g., arterial line, pulse oximeter).
g. Have temporary pacing equipment and an external defibrillator readily available.
h. Keep a magnet immediately available if the pacemaker will respond to a magnet and one is not used for reprogramming.
i. Use continuous cardiac monitoring whenever the pacemaker is deactivated.

6. Perform the following interventions for a patient with an existing non-cardiac IED:
   a. Use alternative technology (e.g., electrocautery, bipolar forceps, ultrasonic technology) instead of monopolar electrosurgery when possible.
   b. Activate the electrosurgical unit for the shortest amount of time possible.
   c. Place the grounding pad as far as possible from the device's generator and leads.
   d. Verify the implanted device and leads are not between the active electrode and the dispersive electrode.
   e. Turn off the IED if it is safe to do so.
7. Take precautions for a patient with an existing cochlear implant:
   a. Do not use electrosurgical devices within 2-3cm of the implant package and electrodes.
   b. Remove all external components.
8. Take precautions for patients who have deep brain stimulators, sacral nerve stimulators, spinal cord stimulators, vagal nerve stimulators, or gastric pacemakers, including turning off the device if so advised by the implant management team and if it is safe to do so.
9. Tri-City Medical Center employees may not deactivate or reactivate a patient's IED.
10. Document IED in the patient's electronic health record (EHR), including all assessments, consultations, interventions and outcomes regarding the IED pre-, intra-, and post-operatively.
11. Provide education to patients and their caregivers on the effects of electrosurgery on IED's.
12. Notify post-operative RN of IED status during hand-off report.

C. **REFERENCES**:

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/15

SUBJECT: Surgical Supply Stocking, Rotation and Outdate

REVISION DATE~~(S)~~: 09/18, 05/20

Surgical Services Department Approval:	**~~02/20~~07/23**
Operating Room Committee Approval:	**~~03/20~~02/24**
Department of Anesthesiology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/20~~03/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**
1. To ensure rotation of sterile supplies so items with the earliest expiration date are used first.
2. To remove items from stock before the expiration date is reached.

B. **POLICY:**
1. All supplies located in the Surgery department shall be checked monthly for package integrity and expiration date.
   a. Materials Management is responsible for checking outdates of all supplies located in Pyxis machines, including Tissue Pyxis.
   b. Operating Room (OR) staff is responsible for checking outdates of items stored in the Surgery department outside Pyxis machines.
   c. OR staff is responsible for checking outdates of all medications stored outside of Medication Pyxis machines.
2. Sterile packages are to be arranged to allow stock rotation on a first in, first out system.
   a. New Items shall be placed in the back, left hand side of the shelf.
   b. Rotate supplies such that items to expire first will be located in the front, right hand side of the shelf.
3. All outdates are to be completed by the last day of each month.
4. Remove items that will expire in the current or following month.
5. Expired items are to be returned to Materials Management department.
6. Document completion of outdates in the Surgery Outdate Log Book, located at the main OR desk..
7. Items are to be checked for package integrity and expiration date prior to being used.
   a. If only the month and year are listed, the day of expiration will be the last day of that month. (i.e. supplies labeled with a 7/2025 expiration would expire on 7/31/2025).
8. Expired items will be reviewed for usage and necessity before reordering. Items which are no longer used or necessary will be removed from inventory.

C. **FORM(S):**
1. Operating Room Outdate Log Book

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

February 29, 2024 – 1:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 1:30 p.m. on February 29, 2024.

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

Director Rocky J. Chavez
Director Nina Chaya
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez

Absent: Director Tracy Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Vice Chairperson, Director Nina Chaya, M.D. called the meeting to order at 1:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Vice Chairperson Chaya made an oral announcement of the items listed on the February 29, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Existing Litigation, one matter of Potential Litigation and Reports Involving Trade Secrets.

6. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Gleason to go into Closed Session at 1:35 p.m. The motion passed (6-0-0-1) with Director Younger absent.

7. At 3:15 p.m. the Board returned to Open Session with attendance as previously noted.

8. Report from Vice Chairperson on any action taken in Closed Session.

Board Counsel Scott stated the report out from closed session will be given at the beginning of today's Regular Board meeting at 3:30 p.m.

9. Open Session

a) Consideration to approve the Joint Marketing Agreement between Tri-City Healthcare District and TriasMD for a term of five (5) years for an expenditure not to exceed $100,000 per year.

It was moved by Director Chavez to approve the Joint Marketing Agreement between Tri-City Healthcare District and Trias MD for a term of five (5) years for an expenditure not to exceed $100,0000 per year. Director Gleason seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

10. Adjournment

There being no further business, Vice Chairperson Chaya adjourned the meeting at 3:20 p.m.

_____
Nina Chaya, M.D.
Vice Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
February 29, 2024 – 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 February 29, 2024.

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

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

Absent was Director Tracy M. Younger

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Janice Gurley, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Susan Bond, General Counsel
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. In Board Chairperson Younger's absence, the Board Vice Chairperson, Nina Chaya, M.D. called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

3. Pledge of Allegiance

   Director Sanchez led the Pledge of Allegiance.

4. Report from Closed Session

   Board Counsel Scott reported the Board conferred with legal counsel concerning existing litigation in the case of Jacobs vs. Tri-City Healthcare District and directed counsel to take appropriate action concerning the existing litigation matter.

   The Board also conferred with legal counsel concerning a potential litigation matter and also directed counsel to take appropriate action.

- Net Operating Revenue – $27,145
- Operating Expense – $27,454
- EBITDA – $2,410
- EROE – $859

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 122
- Adjusted Patient Days – 6,874
- Surgery Cases – 470
- ED Visits – 3,618

Director Mizell asked questions regarding ED volume once the renovation is complete. Dr. Ma explained the ED has been impacted due to the new Kaiser facility and the Urgent Care Center on Jefferson, however we have made significant improvements in permanent staffing and he believes the volume will pick-up.

9. New Business - None

10. Old Business -

a) Affiliation Update –

Dr. Ma shared that we will not meet our initial target of March 31st to have definitive agreements in place with UCSD, however both entities remain very enthusiastic about the opportunity and are working diligently to get through the due diligence.

11. Chief of Staff –

Dr. Henry Showah, Chief of Staff presented the February 2024 Credentialing Actions and Reappointments Involving the Medical Staff. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Coulter to approve the February 2024 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on February 26, 2024. Director Gleason seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

17. Adjournment

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

_____
Nina Chaya, M.D.
Vice Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending February 29, 2024

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	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)	37,447.94	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)	17,052.64	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 Cairsbad** 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)	31,749.00	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)	9,492.42	05/01/23	06/30/25	**Pulmonary Specialists of NC** 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Total				**246,179.06**				

(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 February 2024

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740 BCPS		20924 EDU	200.00	84382	AVANESOV ARTHUR

**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.