TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
May 30, 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	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	2 min.	Chair
3	Roll Call / Pledge of Allegiance		
4	Approval of Agenda	2 min	Standard
5	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
6	Special Recognitions – Nurses & Support Staff of the Year for 2024 ➢ Nurse of the Year (Day Shift): Janette Swanson, RN (2 Pavilion ➢ Nurse of the Year (Night Shift): Jen Catacutan, RN, (PCU) ➢ Patient Care Support Staff of the year: Rick Viela, Anesthesia Tech (Surgical Services)	10 min.	Chair
7	April 2024 Financial Statement Results	10 min.	CFO
8	New Business –None		
9	Old Business – None		

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 Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Departmer located at the Tri-City Medical Center during normal business hours.

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

	Agenda Item	Time Allotted	Requestor
10	Chief of Staff - a) Consideration of May 2024 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on May 28, 2024.	5 min.	COS
11	Consent Calendar (1) Board Committee **(a) Finance, Operations & Planning Committee Director Younger, Committee Chair** 1) Approval of the renewal of a Professional Services Agreement with Aesclapius Medici, Inc. - Dr. Paul Lizotte for a term of 12 months to provide services at Seaside Medical Group of Tri-City beginning May 1, 2024 and ending April 30, 2025, for a total term cost not to exceed $306,000 over a 12-month period. 2) Approval of the renewal of an agreement with Dr. Emad Tadros for the Co-Medical Directorship of the Outpatient Behavioral Health Program for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, for an hourly rate of $144 and an annual cost and total term cost of $89,856. 3) Approval of the renewal of an agreement with Senior Medical Associates (Dr. Tavakoli) for the Co-Medical Directorship of the Outpatient Behavioral Health Program for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, for an hourly rate of $144 and an annual cost and total term cost of $89,856. 4) Approval of an expenditure, not to exceed $325,000 to facilitate the addition of a Physical Medicine and Rehabilitation physician, Christopher Bo, M.D. through a tri-party physician recruitment agreement between Tri-City Healthcare District, North County Neurology Associates and Christopher Bo, M.D. 5) Approval of the bid proposal with Firestone Builders, Inc., not to exceed $442,750 to upgrade the decontamination sink. 6) Approval of an agreement with DaVita, Inc. for inpatient dialysis services for a term of three (3) years, beginning June 1, 2024 and ending May 31, 2027 for an annual cost of $1,240,000 and a total term cost of $$3,657,080. 7) Approval to add Braden McKnight, M.D. to the existing Emergency Department Orthopedics On-Call panel for a term of 15 months, beginning April 1, 2024 and ending June 30, 2025 with no additional cost.	10 min.	Chair

	Agenda Item	Time Allotted	Requestor

8) Approval to add Braden McKnight, M.D. to the existing Emergency Department Spine Surgery On-Call panel for a term of 15 months, beginning April 1, 2024 and ending June 30, 2025 with no additional cost.

9) Approval to add physicians to the existing Emergency Department On-Call panels with no additional cost without Board approval.

(2) Cardiology

a) Approval of the Emergency Department On-Call agreement for STEMI, General Call and Non-Invasive Cardiology Panel services with Karim El Sherief, M.D., Aaron Yung, M.D. Dimitri Sherev, M.D., Mihir Barvalia, M.D., Jesse Naghi, M.D., Fernandez F. Genaro, M.D., and Mohammad Pashmforoush, M.D.,PhD, for a term of 36 months, beginning July 1, 2024 and ending June 30, 2027, with an annual cost of $690,820 and total term cost of $2,072,460.

(3) **Administrative Policies & Procedures**

A. Patient Care Services

1) Abduction Splint Application (Hip) Procedure
2) Code Pink Response Plan Policy
3) Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure
4) Patient Safety in Surgical/Procedural Areas Policy
5) Pet Therapy Policy
6) Plan for Nursing Care
7) Pre-operative Patient Preparation Procedure
8) Specimen Transport to TCMC Main Hospital
9) Surgical Hand Antisepsis Procedure
10) Would Classification During Surgical Intervention

B. Administrative 500

1) Notification to Pre-Hospital Personnel; Exposure to Infectious Disease 530

C. Allied Health Professional

1) Cardiology Standardized Procedures

D. Infection Control

1) Aerosol Transmissible Diseases and Tuberculosis Control Plan
2) Construction

E. Medical Staff

1) Standards for Endovascular Repair of Aortic Aneurysms 8710-503
2) Surgical Assistance 8710-545

F. Outpatient Behavioral health

1) Pastoral Care

G. Progressive Care Unit

1) Release of a Deceased Justice Involved Patient
2) Safety Awareness for Justice involved Patients

H. Surgical Services

1) After Hours Tissue Receiving Policy

	Agenda Item	Time Allotted	Requestor
,	2) Autologous Tissue Preservation and Storage 3) Freeze-Dried Room Temperature Tissue Policy 4) Visitors in the OR Policy (4) Minutes a) Special Meeting – May 2, 2024 b) Regular Meeting – May 2, 2024 (5) Reports – (Discussion by exception only) a) Building Lease Report – April, 2024) b) Reimbursement Disclosure Report – (April 2024)		
12	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
13	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
14	Comments by Chief Executive Officer	5 min.	Standard
16	Board Communications	18 min.	Standard
17	Total Time Budgeted for Open Session	1 hour	
18	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
May 08, 2024

Attachment A

Initial Appointments

Any items of concern will be "red" flagged in this report. Verification of education, training, experience, current competence, health status, current licensure, liability coverage, claims history and the National Practitioner Data Bank, the following practitioners are recommended for a 2-year appointment with delineated clinical privileges, to the Provisional Staff or Allied Health Professional Staff with customary monitoring.

Medical Staff:

Practitioner Name	Group	Specialty	Staff Status	Initial Appointment Term
FREY, Joseph MD	StatRad	Teleradiology	Provisional	5/31/2024 - 5/31/2026
LIZERBRAM, Eric MD	RMG	Radiology	Provisional	5/31/2024 - 5/31/2026
PRESENTE, Asaf MD	Vituity	Critical Care	Provisional	5/31/2024 - 5/31/2026

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
May 8, 2024

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, 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. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Emergency Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
FISCHER, Andrew C., MD	Emergency Medicine	Active	5/31/2024-5/31/2026	

Department of Family Medicine: *None*

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
CHOUDRY, Bilal A., MD	Medicine	Active	5/31/2024-5/31/2026	
KOBAYASHI, Gary L., MD	Medicine	Refer and Follow	5/31/2024-5/31/2026	
KROL, Thomas C., MD	Medicine	Active	5/31/2024-5/31/2026	
LANE, Richard A. MD	Medicine	Active Affiliate	5/31/2024-5/31/2026	Change in staff status from Active to Active Affiliate.
LINSON, Patrick W., MD	Medicine	Active	5/31/2024-5/31/2026	
OMURA, Arthur K., DO	Medicine	Active	5/31/2024-5/31/2026	
WANG, Chunyang T. MD	Medicine	Active	5/31/2024-5/31/2026	

Department of Pathology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
CONTARDO, Marcus MD	Pathology	Active	5/31/2024-5/31/2026	

Department of Pediatrics:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
LEE, Anna E., MD	Pediatrics	Active	5/31/2024-5/31/2026	

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
May 8, 2024

Attachment B

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
RAYAN, Sunil S., MD	General/Vascular Surgery	Active Affiliate	5/31/2024-5/31/2026	
BEN-HAIM, Sharona., MD	Subspecialty of Surgery	Active	5/31/2024-5/31/2026	
GARFF, Kevin J. MD	Subspecialty of Surgery	Active Affiliate	5/31/2024-5/31/2026	
PHILLIPS, Jason., MD	Subspecialty of Surgery	Active	5/31/2024-5/31/2026	
TUNG, Howard., MD	Subspecialty of Surgery	Active	5/31/2026-5/31/2026	

Resignations *Medical Staff and AHP*:

Practitioner Name	Department/Specialty	Reason for Resignation
DAVIES, James MD	Surgery/Ophthalmology	Voluntary Resignation- Per practitioner's letter: effective 03/15/2024
HAMILTON Jr., James PA	Surgery/Physician Assistant	Voluntary Resignation- Per practitioner's letter: effective 03/05/2024
HAMMOND, Hilary PA	Surgery/Physician Assistant	Voluntary Resignation- Per employer's letter: effective 04/01/2024
KAO, Jerry MD	Pathology	Voluntary Resignation- Per practitioner's letter: effective 09/01/2023
KARACHALIOS, Michael MD	Radiology/Teleradiology	Voluntary Resignation – Per practitioner's letter, effective 04/09/2024
MCCLAY, Edward F., MD	Medicine/ Internal Medicine	Voluntarily Resignation- Per practitioner's letter: effective 9/01/2024, therefore will not move forward with Reappointment.
SUPAT, Benjamin MD	Emergency Medicine	Voluntary Resignation- Per practitioner's letter: effective 05/30/2024
YUNG, Le T., MD	Medicine/Internal Medicine	Voluntary Resignation- Per practitioner's letter: effective 05/30/2024
JAFFER, Jihad., MD	Medicine/Physical Medicine & Rehab	Voluntarily Resignation: Due to failure to submit reappointment application: effective 5/31/2024

MBOC (Medical Board of California): No new information at this time

NPDB (National Practitioner Data Bank): No new information at this time

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
May 08, 2024

Modification of Staff Status

The following practitioners have requested privilege status change as noted below. Effective **[5/31/2024]**.

Practitioner Name	Department/Specialty	Change in Staff Status
KHALESSI, Alexander MD	Surgery/Neurosurgery	Change in staff status from Refer and Follow to Active Affiliate.

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective **[5/31/24]**.

Practitioner Name	Department/Specialty	Change in Privilege/s
KHALESSI, Alexander MD	Surgery/Neurosurgery	Additional Privileges: Admit, Consultation, H & P, Cranial/Skull Base Category, Spine Category excluding Vertebral Augmentation, Nervous System Category, Moderate Sedation and Fluoroscopy.

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
May 22, 2024

Members Present	Director Tracy Younger, Dr. Mohammad Jamshidi-Nezhad, Dr. Henry Showah (arrived 12:20pm)
Non-Voting Members Present:	Dr. Gene Ma, CEO; Janice Gurley, CFO; Roger Cortez, CCO; Mark Albright, CIO Jeremy Raimo, COO; Susan Bond, General Counsel
Others Present	Director George Coulter (given proxy from Director Nina Chaya in her absence), Miava Sullivan, Tony Vitrano, Benny Oporto, Joanne Barnett
Members Absent:	Director Nina Chaya, Director Adela Sanchez, Donald Dawkins, CNE

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Younger called the meeting to order at 12:10 pm.		Chair
2. Approval of Agenda		**MOTION** **It was moved by Director Coulter, and seconded by Dr. Jamshidi-Nezhad to approve the agenda of May 22, 2024.** **Members:** **AYES: Younger, Coulter (Proxy), Dr. Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Sanchez, Director Chaya**	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Younger read the paragraph regarding comments from members of the public.	No comments	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
4. Ratification of minutes of February 21, 2024	Minutes were ratified.	**MOTION** **It was moved by Dr. Jamshidi-Nezhad and seconded by Director Coulter to approve the minutes of February 21, 2024.** **Members:** **AYES: Younger, Coulter (Proxy), Jamshidi-Nezhad** **NOES: None** **ABSTAIN: None** **ABSENT: Director Sanchez, Director Chaya**	Chair
5. Old Business	None		
6. New Business	None		Chair
7. Consideration of Consent Calendar:		**MOTION** **It was moved by Dr. Jamshidi-Nezhad to approve the Consent Calendar and seconded by Director Coulter.** **Members:** **AYES: Younger, Coulter (Proxy), Dr. Mohammed-Jamshidi** **NOES: None** **ABSTAIN: None** **ABSENT: Director Sanchez, Director Chaya**	Chair
a) Professional Services Agreement Renewal Aescalapius Medici, Inc. • Dr. Paul Lizotte		**Approved via Consent Calendar**	Jeremy Raimo
b) Physician Agreement Co-Medical Director – Outpatient Behavioral Health Services • Emad Tadros, M.D.		**Approved via Consent Calendar**	Donald Dawkins/Tony Vitrano
c) Physician Agreement Co-		**Approved via Consent Calendar**	Donald

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Medical Director – Outpatient Behavior Health Services • Senior Medical Associates (Jason Keri as signer & Dr. Tavakoli as the covering physician)			Dawkins/Tony Vitrano
d) Physician Recruitment Agreement • Christopher Bo, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
e) Bid Proposal – Sterile Processing Department Sink Replacement • Firestone Builders, Inc.		**Approved via Consent Calendar**	Jeremy Raimo/Benito Oporto
f) Dialysis Services Proposal • DaVita, Inc.		**Approved via Consent Calendar**	Donald Dawkins/Joanne Barnett
g) Physician Agreement for ED On-Call Coverage - Orthopedics • Braden McKnight, M.D.		**Approved via Consent Calendar**	Jeremy Raimo
h) Physician Agreement for ED On-Call Coverage – Spine Surgery • Braden McKnight, M.D.	Jeremy Raimo noted the committee previously agreed in September, 2023 to waive Board approval for those physicians who are simply joining an existing call panel with no additional cost.	**Approved via Consent Calendar** **Going forward, the addition of physicians to ED Call panels with no additional cost will not require Board approval.**	Jeremy Raimo
8. Financials	Janice Gurley presented the financials ending April 30, 2024 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 242,714 Operating Expense $ 275,833 EBITDA $ (8,570) EROE $ (23,919) **TCMC – Key Indicators**		Janice Gurley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Fiscal Year to Date Avg. Daily Census 115 Adjusted Patient Days 67,367 Surgery Cases 4,095 ED Visits 36,623 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 27,194 Operating Expense $ 27,929 EBITDA $ 1,977 EROE $ 479 **TCMC – Key Indicators** **Current Month** Avg. Daily Census 128 Adjusted Patient Days 7,490 Surgery Cases 451 ED Visits 3,744 **Graphs:** • TCHD-EBITDA and EROE • TCMC-Average Daily Census, Total Hospital - Excluding Newborns • TCMC-Emergency Department Visits • TCMC-Acute Average Length of Stay • TCMC-Adjusted Patient Days		
a. Dashboard	No discussion	Information Only	Janice Gurley
9. Comments by Committee Members	None		Chair
10. Date of next meeting	June 19, 2024		Chair
11. Adjournment	Meeting adjourned 12:35 pm		Chair

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 22, 2024
PROFESSIONAL SERVICES AGREEMENT RENEWAL

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

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

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

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

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

Monthly Cost	12 Month (Term) Cost
$25,500	$306,000

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

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

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize through a Professional Services Agreement with Aescalapius Medici, Inc. – Dr. Paul Lizotte for a renewal term of 12 months to provide professional services at Seaside Medical Group of Tri-City May 1, 2024 and ending April 30, 2025, for a total term cost not to exceed $306,000 over a 12-month period.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING MEETING
DATE OF MEETING: May 22, 2024
PHYSICIAN AGREEMENT CO-MEDICAL DIRECTOR – OUTPATIENT BEHAVIORAL HEALTH SERVICES

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

Physician's Name: Emad Tadros, M.D.

Area of Service: Outpatient Behavioral Health - Morning and Afternoon Program

Term of Agreement: 12 months, Beginning, July, 1, 2024 – Ending, June 30, 2025

Maximum Totals: Within Hourly Fair Market Value.

	Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 Month (Term) Cost
Medical Director Duties	$144	32	384	$4,608	**$55,296**
Case Care Management Duties	$144	16	192	$2,304	**$27,648**
Vacation Coverage	$144	As needed (0-8)	48 max.	$576	**$6,912**
	Total:	**52**	**624**	**$7,488**	**$89,856**

Co-Medical Director Responsibilities:

- Provide medical supervision and direction to the unit, including the morning, afternoon and evening programs
- Supervise and promote the quality of care and evaluate delivery systems.
- Oversee the development of evidence-based clinical services and provide psychiatric expertise.
- Facilitate weekly problem solving and treatment team meetings with clinical staff.
- Review all treatment plans at least monthly to determine appropriateness of problems and treatment goals.
- Evaluate and review policies and procedures and make suggestions for changes as appropriate.
- Provide education to other physicians ahttps://kasa-solutions.com/proposed-legislation-allows-lmft-lmhc-bill-medicare/nd departments regarding intensive outpatient level of care

Case Care Management and other Duties:

- Take on utilization management duties and respond to insurance authorization calls for IOP and communicate clinical determination of medical necessity
- Evaluate patients at least once per month for medical necessity and discharge readiness
- Evaluate whether patients are medically stable and meet inclusion/exclusion criteria for IOP on admission and monthly thereafter.
- Prepare reports and records as requested by hospital and regulatory bodies
- Provide professional guidance to staff Monday through Friday and evaluate risk/protective factors and recommend whether a patient needs inpatient treatment or can be managed with safety planning. Respond to calls Mondays through Fridays, 8 am-5 pm.

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

Person responsible for oversight of agreement: Tony Vitrano-Operations Manager, Outpatient Behavioral Health / Donald Dawkins, Chief Nurse Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of an agreement with Dr. Emad Tadros for the Co-Medical Directorship of the Outpatient Behavioral Health Program for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, for an hourly rate of $144 and an annual cost and total term cost of $89,856.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING MEETING
DATE OF MEETING: May 22, 2024
PHYSICIAN AGREEMENT CO-MEDICAL DIRECTOR – OUTPATIENT BEHAVIORAL HEALTH SERVICES

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

Physician's Name: Senior Medical Associates (Jason Keri as signer & Dr. Tavakoli as the covering physician)

Area of Service: Outpatient Behavioral Health

Term of Agreement: 12 months, Beginning, July, 1, 2024 – Ending, June 30, 2025

Maximum Totals: Within Hourly Fair Market Value.

	Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	12 Month (Term) Cost
Medical Director Duties	$144	32	384	$4,608	**$55,296**
Case Care Management Duties	$144	16	192	$2,304	**$27,648**
Vacation Coverage	$144	As needed (0-8)	48 max.	$576	**$6,912**
	Total:	**52**	**624**	**$7,488**	**$89,856**

Co-Medical Director Responsibilities:

- Provide medical supervision and direction to the unit, including the morning, afternoon and evening programs
- Supervise and promote the quality of care and evaluate delivery systems.
- Oversee the development of evidence-based clinical services and provide psychiatric expertise.
- Facilitate weekly problem solving and treatment team meetings with clinical staff.
- Review all treatment plans at least monthly to determine appropriateness of problems and treatment goals.
- Evaluate and review policies and procedures and make suggestions for changes as appropriate.
- Provide education to other physicians regarding intensive outpatient level of care

Case Care Management and other Duties:

- Take on utilization management duties and respond to insurance authorization calls
- Evaluate patients at least once per month for medical necessity and discharge readiness
- Evaluate whether patients are medically stable and meet inclusion/exclusion criteria for IOP on admission and monthly thereafter.
- Prepare reports and records as requested by hospital and regulatory bodies
- Provide professional guidance to staff and evaluate need for hospitalization

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

Person responsible for oversight of agreement: Tony Vitrano - Operations Manager, Outpatient Behavioral Health / Donald Dawkins, Chief Nurse Executive

Motion:
I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the renewal of an agreement with Senior Medical Associates (Dr. Tavakoli) for the Co-medical Directorship of Outpatient Behavioral Health Program for a term of 12 months, beginning July 1, 2024 and ending June 30, 2025, for an hourly rate of $144 and an annual and total term cost of $89,856.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 22, 2024
PHYSICIAN RECRUITMENT AGREEMENT

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

Physician Name: Christopher Bo, M.D.

Practice Name: North County Neurology Associates

Areas of Service: Physical Medicine and Rehabilitation

Key Terms of Agreement:

Effective Date: September 1, 2024, or the date Dr. Bo becomes a credentialed member in good standing of the Tri-City Healthcare District Medical Staff.

Community Need: TCMC is developing a succession plan for Medical Direction of the Inpatient Rehabilitation Unit for the existing provider who is anticipated to step down from the role within the year.

Service Area: Area defined by the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients

Terms of the Engagement:	Proposal Costs:
Monthly Professional Stipend	$25,000 per month ($300,0000 a year)
Sign-On Advance	$15,000
Relocation Allowance	$10,000
Total Amount of Request:	**$325,000**

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

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

Motion:
I move that the Finance, Operations & Planning Committee approve expenditure, not to exceed $325,000, to facilitate the addition of a Physical Medicine and Rehabilitation physician, Christopher Bo, M.D. to practice medicine in the communities served by the District. This will be accomplished through a tri-party physician recruitment agreement (not to exceed a one-year income guarantee with a two-year forgiveness period) between Tri-City Healthcare District, North County Neurology Associates and Christopher Bo, M.D.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: MAY 22, 2024
STERILE PROCESSING DEPARTMENT SINK REPLACEMENT

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

Vendor's Name: Firestone Builders, Inc.

Area of Service: Sterile Processing Department

Term of Agreement: Construction Bid Proposal – Estimated completion is 7-8 months from approval

Maximum Totals:

Total Cost
Proposal = $385,000
15% Contingency = $57,750
Not to Exceed = $442,750

Description of Services/Supplies:

- District upgrading scope decontamination sink
- District has received one bid proposal for the project
- Scope of the project – replace existing sink upgraded sink, retrofit the underground plumbing and add new electrical circuits for other sterile processing equipment.

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

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

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the bid proposal with Firestone Builders, Inc., not to exceed $442,750 to upgrade the decontamination sink.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: MAY 22, 2024
DIALYSIS SERVICES PROPOSAL

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

Vendor's Name: DaVita, Inc.

Area of Service: Patient Care Services

Term of Agreement: 36 months, Beginning, June 1, 2024 – Ending, May 31, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$96,000 - $110,000	$1,240,000	**$3,657,080**
Based on Treatment Volume	Includes: Year #1 start-up of $84,000, then approximately $1,156,000 with a 3% annual adjustment	

Description of Services/Supplies:

- DaVita is Joint Commission certified and will provide all inpatient dialysis services and oversight of the program to include staffing, quality, equipment and preventative maintenance
- 2 vendors were reviewed for quality and cost per treatment
- Projected annual cost was reviewed based on current vendor- DaVita requires a one-time start-up cost with of 84,000, and overall annual cost is lower than current vendor with no lapse in current dialysis services
- Annualized cost is based on census and volume of services in 2023

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

Person responsible for oversight of agreement: Donald Dawkins, Chief Nurse Executive / Joanne Barnett, Sr. Nursing Director

Motion:
I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with DaVita, Inc. inpatient dialysis services, for a term of 3 years, beginning June 1, 2024 and ending May 31, 2027 for an annual cost of $1,240,000, and a total cost for the term of $3,657,080.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 22, 2024
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ORTHOPEDICS

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

Physician's Name: Braden McKnight, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 15 months, Beginning, April 1, 2024, ending June 30, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call Agreement with Entire ED call panel for Orthopedic Surgery with no additional cost.

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer / Bert Lawson, Director ER

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the addition of Braden McKnight, M.D. to the Orthopedics Emergency Department Call Panel for a term of 15 months, April 1, 2024 – June 30, 2025 with no additional cost.

Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: May 22, 2024
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – SPINE SURGERY

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

Physician's Name: Braden McKnight, M.D.

Area of Service: Emergency Department On-Call: Spine Surgery

Term of Agreement: 15 months, Beginning, April 1, 2024, ending June 30, 2025

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call Agreement with Entire ED call panel for Orthopedic Spine Surgery with no additional cost.

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Chief Operating Officer / Bert Lawson, Director ER

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the addition of Braden McKnight, M.D. to the existing Emergency Department Spine Surgery On-Call panel for term of 15 months, Beginning, April 1, 2024 – June 30, 2025 with no additional cost.

Tri-City Medical Center

Discussion Item:

Discuss Addition of Physician(s) to Approved Panel & ED On-Call Agreements, Which Would Be Co-Terminus for Such Agreements

Dr. Gene Ma, Chief Executive Officer

Tri-City Medical Center

TCHD BOARD OF DIRCTORS
DATE OF MEETING: May 30, 2024
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE (General and STEMI) and Non-Invasive Cardiology Panel

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

Vendor's Name: Karim El-Sherief, M.D., Aaron Yung, M.D., Dimitri Sherev M.D., Mihir, Barvalia M.D., Jesse, Naghi M.D., Fernandez F. Genaro, M.D., Mohammad Pashmforoush M.D. PhD

Area of Service: Emergency Department On-Call: Cardiology, STEMI and Non-Invasive Cardiology Panel

Term of Agreement: 36 months, Beginning, July 1, 2024 - Ending, June 30, 2027

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
No increase in expense

	Rate/Day	**Annual Cost**	**Term Cost**
STEMI	$1,000	$365,000	$1,095,000
GENERAL	$300	$109,500	$328,500
	Rate/Week	**Annual Cost**	**Term Cost**
CARDIOLOGY PANEL	$4,160	$216,320	$648,960
		$690,820	**$2,072,460**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Cardiology STEMI specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Non-Invasive Cardiology Panel Physician shall interpret echocardiograms, EKG studies of unassigned patients and perform and interpret all pharmacological stress tests

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

Person responsible for oversight of agreement: Gene Ma, CEO / Eva England, Sr. Director, Ancillary Services

Motion:

I move that the TCHD Board of Directors approve the Emergency Department On-Call agreement for STEMI, General Call and Non-Invasive Cardiology Panel services with Karim El-Sherief, M.D., Aaron Yung, M.D., Dimitri Sherev, M.D., Mihir, Barvalia, M.D., Jesse, Naghi, M.D., Fernandez F. Genaro, M.D. and Mohammad Pashmforoush, M.D. PhD for a term of 36 months, beginning July 1, 2024 and ending, June 30, 2027, with an annual cost of $690,820 and total term cost of $2,072,460.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
May 21st, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Abduction Splint Application (Hip) Procedure	3 year review	Forward to BOD for Approval
2. Code Pink Response Plan Policy	Practice change	Forward to BOD for Approval
3. Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure	3 year review	Forward to BOD for Approval
4. Patient Safety in Surgical/ Procedural Areas Policy	3 year review	Forward to BOD for Approval
5. Pet Therapy Policy	3 year review, practice change	Forward to BOD for Approval
6. Plan for Nursing Care	Practice change	Forward to BOD for Approval
7. Pre-Operative Patient Preparation Procedure	3 year review, practice change	Forward to BOD for Approval
8. Specimen Transport to TCMC Main Hospital Laboratory from Off-Site Facilities	3 year review	Forward to BOD for Approval
9. Surgical Hand Antisepsis Procedure	3 year review, practice change	Forward to BOD for Approval
10. Wound Classification During Surgical Intervention	3 year review	Forward to BOD for Approval
Administrative 500		
1. Notification to Pre-Hospital Personnel; Exposure to Infectious Disease 530	3 year review, practice change	Forward to BOD for Approval
Allied Health Professional		
1. Cardiology Standardized Procedures	RETIRE	Forward to BOD for Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	1 year review, practice change	Forward to BOD for Approval
2. Construction	Practice change	Forward to BOD for Approval
Medical Staff		
1. Standards for Endovascular Repair of Aortic Aneurysms 8710-503	3 year review	Forward to BOD for Approval
2. Surgical Assistance 8710-545	Practice change	Forward to BOD for Approval
Outpatient Behavioral Health		
1. Pastoral Care	3 year review, practice change	Forward to BOD for Approval
Progressive Care Unit		

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
May 21st, 2024

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
1. Release of a Deceased Justice Involved Patient	3 year review, practice change	Forward to BOD for Approval
2. Safety Awareness for Justice Involved Patients	3 year review	Forward to BOD for Approval
Surgical Services		
1. After Hours Tissue Receiving Policy	3 year review	Forward to BOD for Approval
2. Autologous Tissue Preservation and Storage	3 year review	Forward to BOD for Approval
3. Freeze-Dried Room Temperature Tissue Policy	3 year review	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ABDUCTION SPLINT APPLICATION (HIP)**
Purpose:	To outline the nursing responsibilities when applying an abduction splint or abduction wedge.
Supportive Data:	Splints maintain hip abduction to prevent dislocation **and internal rotation** in total hip replacement patients. Application requires a physician order.
Equipment:	Abduction Splint

A. **APPLICATION:**

1. Verify physician order.
2. Explain procedure to patient.
3. Position splint so the top is as close to patient's perineum as possible.
4. Place patient's leg on either side of the splint.
5. Run dorsal straps under patient's thigh and calf.
6. Bring dorsal straps around patient's leg to anterior section and apply Velcro straps (snugly, but not restricting venous flow).
7. Ensure splint is in proper placement prior to turning and/or after repositioning patient.
8. Loosen Velcro straps on patients received from Post-Anesthesia Care Unit (PACU) on arrival to unit and every four hours for skin inspection of pressure points and alignment.
9. Assess splint alignment to patient on arrival to unit and every four hours.
10. Assess patient's skin for pressure points every four hours and PRN.
11. Document presence of abduction splint in the medical record.

B. **REFERENCES:**

1. Elsevier Clinical Skills. (n.d.). *Immobilization Devices Extended Text.* Retrieved 11.25.2019, from point-of-care.elsevierperformancemanager.com/skills: https://point-of-care.elsevierperformancemanager.com/skills/336/extended-text?skillId=GN_12_5#scrollToTop
2. ~~National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.~~
3. ~~NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.~~**Alexander's Care of the Patient in Surgery, 16th Edition, Rothrock, Jane C., 2019.**

Department Review	Clinical Policies & Procedures	Nursing Leadership	Division of Orthopedics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/93; 02/11, 10/15, 10/19, **04/23**	03/11, 11/15, 12/19, 03/20, **05/23**	03/11, 12/15, 04/20, **06/23**	05/16, 05/20, **04/24**	n/a	04/11, 10/16, 06/20, **04/24**	07/20, **05/24**	05/11, 01/17, n/a	5/93, 5/00, 6/00, 7/03, 1/06; 6/08; 05/1, 01/17, 08/20

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

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

REVISION DATE: 11/02; 03/03, 05/05, 05/06, 11/07, 01/08, 01/09, 02/10, 05/11, 03/16 08/22

Patient Care Services Content Expert:	~~02/20~~12/23
Clinical Policies & Procedures Committee Approval:	~~04/20~~12/23
Nursing Leadership Approval:	~~05/20~~01/24
Perinatal Collaborative Practice Approval:	~~09/20~~ n/a
Department of Emergency Medicine Approval:	~~04/22~~04/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/22~~04/24
Administration Approval:	~~08/22~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/22

A. **PURPOSE:**
1. To provide a systematic method for responding to a cardiopulmonary emergency on children ages ~~3~~0 days through 13 years within the hospital and outside of the facility on hospital property.

B. **DEFINITIONS:**
1. Child: pediatric patient 30 days old through 13 years. Pediatric Advanced Life Support (PALS) guidelines shall be used to direct resuscitative efforts.
2. Code Pink Response Areas:
   a. Patient Care Areas – areas in the main building with crash carts and AED/debrillators available (for example Cardiac Rehabilitation building and Magnetic Resonance Imaging [MRI] building).
   b. Non-patient Care Areas: areas on the main campus where crash cart and AED/debrillators not available (for example the Business Administration Management [BAM] building, registration and parking area).

C. **POLICY:**
1. A Code Pink shall be called on any apneic and/or pulseless child.
2. Any person may initiate a Code Pink by dialing "66" on the telephone. The operator shall announce "Code Pink" and the location over the P.A. system three times, twice.
3. Response to the Code shall occur according to the following response plan.

D. **RESPONSE PLAN WITHIN PATIENT CARE AREAS:**
1. Code Pink initiation
   a. Staff shall initiate Basic Life Support (BLS) measures until Code Pink Response Team arrives.
2. Code Pink response team:
   a. Emergency Department (ED) Registered Nurse (RN).
      i. Initiates Standardized Procedure for Code Pink Resuscitation until the physician arrives.
      ii. Remains with patient until transport team arrives or nurse transports patient to appropriate area as ordered by physician.

i. Maintains scene safety and keeps area clear of congestion

F. **RESPONSE PLAN AT AFFLIATED CENTERS:**

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

G. **REFERENCES:**

1. American Heart Association. (**2020**~~2015~~). BLS for healthcare providers: *Professional Student Manual.*
~~2. American Heart Association (AHA) (2015). Highlights of 2010 aha guidelines for CPR~~
~~3. American Heart Association (AHA) (2015). Handbook of emergency cardiovascular care for healthcare providers.~~
~~4.~~**2.** Pediatric advanced life support. (20**20**~~15~~). American Heart Association (AHA).

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**KNEE IMMOBILIZER APPLICATION AND RANGE OF MOTION (ROM) BRACE**
Purpose:	To outline the nursing responsibilities in the application of knee immobilizer.
Supportive Data:	Knee immobilizers provide support to prevent knee flexion. Requires a physician order.
Equipment:	Knee immobilizer/universal knee splint; ROM brace.

A. **KNEE IMMOBLIZER:**

1. Assess neurovascular status and skin integrity of patient pre and post application of splint and ongoing (ie. minimum every 4 hours or per physician orders). Include proper placement of the splint while splint is on.
2. Place leg inside immobilizer with posterior fossa resting in posterior panel so that when the immobilizer is secured, it is in alignment with patella if visible (if not compare with contra-lateral patella). It is not necessary for the patella strap to fasten.
3. Apply Velcro straps through metal loops snugly, s but not restricting venous flow.
4. Record neurovascular assessment, application of immobilizer/splint, and patient's tolerance in the medical record.

B. **RANGE OF MOTION (ROM) BRACE:**

1. Assess neurovascular status and skin integrity of patient pre and post application of brace. (ie. minimum every 4 hours or per physician orders.)
2. Set dial for extension and flexion per physician order.
3. Open brace and place under leg. Line padding up for lower and upper sections of leg and making sure that circular padding lines up with knee joint, using popliteal fossa as a point of reference.
4. Close padding with Velcro, starting at the bottom and working upwards.
5. Apply Velcro straps snugly, but not restricting venous flow.
6. Record neurovascular assessment, application of brace, and patient's tolerance in the medical record.

C. **REFERENCES:**

1. Elsevier Clinical Skills. (n.d.). *Splinting: Knee Immoblization Extended Text.* Retrieved **06.07.2023**~~11.25.2019~~, from **https://point-of-care.elsevierperformancemanager.com/skills/241/extended-text?skillId=EN_125&virtualname=tricity-caoceanside#scrollToTop**~~https://point-of-care.elsevierperformancemanager.com/skill: https://point-of-care.elsevierperformancemanager.com/skills/241/extended-text?skillId=EN_125#scrollToTop~~
2. National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 7th Edition.
3. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Division of Orthopedics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/93, 01/11, 10/19, **04/23**	02/11, 11/15, 12/19, 03/20, **05/23**	03/11, 12/15, 04/20, **06/23**	05/16, 05/20, **04/24**	n/a	04/11, 10/16, 06/20, **04/24**	07/20, **05/24**	05/11, 02/17, n/a	12/93, 5/00, 6/00, 7/03, 1/06, 6/08, 05/11, 02/17, 08/20

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/94 **SUBJECT:** Patient Safety in Surgical/Procedural Areas

REVISION DATE: 07/13~~;~~, 01/14, 03/16, 11/20

Patient Care Services Content Expert:	~~03/20~~08/23
Clinical Policies & Procedures Committee Approval:	~~04/20~~09/23
Nursing Leadership ~~Committee~~Approval:	~~05/20~~10/23
Operating Room Committee	~~06/20~~02/24
Environmental Health and Safety Committee Approval:	04/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~09/20~~04/24
Administration Approval:	~~10/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. **PURPOSE:**

1. To provide guidelines for the implementation of safe care to patients and assist in the identification of potential hazards.

B. **POLICY:**

1. Potential hazards associated with controlling the patient's temperature shall be identified, and safe practices shall be established.
   a. When assessing the need for devices to monitor and/or control patient temperature, the following factors shall be considered in collaboration with the perioperative team members (i.e., Anesthesiologist, Surgeon, Perioperative Registered Nurse [RN]), according to AORN Guidelines for Perioperative Practice:
      i. Patient's age
      ii. Patient's physical status
      iii. Type of anesthesia used
      iv. Ambient room temperature
      v. Length and type of surgical procedure
      vi. Patient positioning
      vii. Warming equipment constraints or potential for adverse events associated with use of warming equipment.
   b. Maintenance of optimum patient temperature shall begin in the preoperative phase and continue into the postoperative phase. Perioperative nursing interventions include, but are not limited to:
      i. Applying forced air pre-warming gown and device in pre-operative area
      ii. Applying warm blankets to the patient on his/her arrival to the surgical area, and after sterile drapes have been removed
      iii. Limiting the amount of patient skin surface exposure during positioning and skin preparation
      iv. Limiting the time between skin prepping and surgical draping (Note: alcohol-based preps must be allowed a minimum of 3 minutes to dry before draping)
      v. Preventing surgical drapes from becoming wet, if possible
      vi. Increasing the ambient room temperature
      vii. Using heat/cooling maintenance devices intraoperatively
      viii. Providing surgical team members with warmed/cooled irrigation/infusion solutions as necessary

c. Temperature regulating devices shall be used according to manufacturer's recommendations.
   i. Forced air warming devices must only be used with the manufacturer recommended blanket/gown. "Hosing," or applying the hose of the forced air warming device directly under blankets or drapes, is not allowed.
   ii. Direct patient skin contact with plastic surfaces (for example Hosing) of temperature regulating blankets/gowns shall be avoided.
   iii. Folds and creases in temperature regulating blankets/gowns shall be avoided.
   iv. Do not allow the hose of the forced air warming device to contact the patient, even when using the properly attached gown or blanket. Maintain adequate tension on the hose to keep it from touching the patient.
   v. When using a forced air warming blanket with a head drape, arrange the drape in a manner that allows the air to flow freely from under the drape, and keep the blower activated while the drape is in place.

d. Temperature regulating devices shall be assigned identification numbers (or use the serial numbers) and documented in the OR Record.

e. Skin integrity shall be inspected before, periodically during (if possible), and after the use of temperature regulating devices.

f. Irrigation/infusion solutions shall be warmed / cooled to temperatures appropriate for the surgical needs and according to manufacturer's recommendations.
   i. Microwave ovens/autoclaves shall not be used to warm solutions.

2. Potential hazards associated with chemicals used in surgery/procedural areas shall be identified, and safe practices shall be established for their use.
   a. Personnel shall be informed of the hazards associated with the chemicals used in their practice setting.
   b. Safety Data Sheets (SDS) shall be accessible within the practice setting.
   c. The mixing/combining of chemicals shall be avoided unless safe outcomes can be ensured.
   d. Decanting or transferring of solutions/chemicals from the primary container to another container should be avoided unless no other option exists or the solution/chemical is intended to be decanted.
      i. Containers used for decanted solutions must be labeled with all appropriate and necessary product information including name, strength, uses, precautions and SDS information.

3. Potential hazards associated with the use of electrical equipment in surgery/procedural areas shall be identified, and safe practices established.
   a. All electrical equipment shall be inspected before use, including but not limited to:
      i. Checking power outlet and switch plates for damage
      ii. Checking power cords and plugs for fraying or other damage
      iii. Biomedical or electrical safety inspections of all new, rented, leased, or borrowed equipment before it is placed in the practice setting
   b. Equipment cord length shall be appropriate for the intended use of the item:
      i. Extension cords shall not be used in the surgical setting
      ii. Power strips may be used in the surgical setting under the following conditions:
         1) Only use hospital-grade power strips which have been approved by Clinical Engineering and Biomed departments
         2) Do not exceed 75% of the power strip capacity
   c. Line isolation monitoring systems or ground fault interrupting systems shall provide continuous monitoring of electrical current leakage.
   d. Any malfunctioning electrical equipment shall be immediately removed from use:
      i. Equipment failures which involve potential injury, injury or death to a patient will be secured, investigated and reported in accordance with Local, State and Federal Regulations.
      ii. These incidents shall be immediately reported to the **Nurse Leader**~~Charge Nurse~~, Supervisor, Biomedical Engineering, Safety Officer and Risk Management.

4. Potential environmental hazards that affect patient care shall be identified, and safe practices shall be established.
    a. The use of medical gases in the surgical area shall meet all established regulations and standards including, but not limited to:
        i. No flammable gases shall be used in the surgical area
        ii. All free standing gas cylinders shall be properly chained for support or in a portable holder or storage container
        iii. All anesthesia machines and related equipment shall be constructed so that connections for different gases are not interchangeable
        iv. Staff members shall demonstrate knowledge concerning the use, handling, storage, and disposal of gas cylinders
        v. Cylinders shall be stored in designated locations, in a quantity allowed by policy
    b. The number of air exchanges per hour, temperature, and humidity in anesthetizing locations shall meet the established regulations and standards (California Code of Regulations Title 24).
        i. Temperature and relative humidity levels in anesthetizing locations are maintained and tracked by Plant Operations.
            1) The Building Management System shall be programmed to track and record the relative humidity levels continuously and alert the duty plant engineer if the humidity drops below 20%.
            2) Plant engineering staff shall take corrective action and notify Surgery department and procedural areas when relative humidity drops below 20%.
        ii. When notified by Plant Operations that temperature or humidity are out of range, the Engineering Department (high or low temperature or humidity) are consulted to determine appropriate actions.
        iii. The use of portable humidifiers or dehumidifiers in the OR is not permitted.
    c. Floors shall be clean, dry, unobstructed, and in good repair.
    d. Lighting shall be adequate for:
        i. Illuminating the surgical field
        ii. Monitoring the patient
        iii. Performing perioperative duties
5. Isolation techniques for preventing the transmission of infectious agents shall be identified and established.
    a. Specific techniques shall relate to the risk levels of the infectious agents and be developed in conjunction with Infection Control practitioners using the Centers for Disease Control and Prevention guidelines and other appropriate agencies.

C. **REFERENCES:**

1. California Code of Regulations Title 24
2. AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.
3. ASHRAE Technical Committee 9.6, Healthcare Facilities. (2019). *Humidity Control Events in Perioperative Care Areas*. www.ashrae.org.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 05/06 **SUBJECT:** Pet Therapy

REVISION DATE: 07/06, 08/08, 07/11, 02/15, 12/17

Patient Care Services Content Expert Approval:	~~08/20~~01/24
Clinical Policies & Procedures Committee Approval:	~~08/20~~01/24
Nursing Leadership Approval:	~~10/20~~02/24
Infection Control Committee Approval:	~~10/20~~03/24
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/20~~04/24
Administration Approval:	~~12/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/20

A. **PURPOSE:**

1. Pet Therapy is utilized to make hospitalization a less threatening experience and promote therapeutic patient goals. It is used to augment healing and to provide incentives to patients who are debilitated and/or uncommunicative.

B. **POLICY:**

1. All patients of Tri-City Healthcare District (TCHD) are eligible, but must be authorized, for participation in the program in order to promote cognitive skills, physical functioning and improve patient psycho-social well-being.
2. Patients of TCHD may request specific visitation on Acute Rehabilitation, Inpatient/Out Patient Behavioral Health, Cardiac **Rehabilitation**~~Wellness~~, 4 Pavilion, 2 Pavilion, 1 North, Telemetry, and Emergency Services.
    a. Therapy dogs may not visit unauthorized areas or patients with the following:
        i. Shared rooms, unless both patients agree.
        ii. Patients with spleen removed or immuno compromised (neutropenic)
        iii. If an immuno compromised patient would like a pet therapy visit this is determined at the discretion of the patient's physician.
            1) Infection Control must be consulted before permitting pet visits for patients in various immune deficiency states.
        iv. Patients in isolation (Airborne, Droplet and Contact) including patients with:
            1) Tuberculosis (dogs and handlers can acquire tuberculosis).
            2) Patients with positive test for methicillin-resistant Staphylococcus aures (MRSA); dogs and their handlers can acquire MRSA.
            3) Patients colonized or infected with vancomycin-resistant enterococci (VRE), Salmonella, Campylobacter, Shigella, Strep A, Ringworm, Giardia, or Amebiasis.
        v. Food preparation area or carts.
        vi. Medication preparation or storage area or carts.
        vii. High risk areas; ~~I~~intensive ~~C~~care ~~Unit~~, **procedural** ~~Operating rooms and Neonatal Intensive Care Unit~~ and patients **receiving**~~on~~ dialysis.
3. Personal pets are not permitted in the hospital unless they are a service animal or an approved Pet Therapy dog:

~~a. Exceptions shall be made through hospital administration with consultation from Infection Control.~~

~~b.~~**a.** Strict guidelines and criteria for approved Pet Therapy handlers and their dogs are outlined in the reference listed below.

4. Only Active members of **Tri-City Hospital Auxiliary (TCHA)** Tender Loving Canines (TLC) Program are authorized to perform service with dogs and handlers who are registered ~~with Pet Partners, Independent Therapy Dogs, Inc., or other therapy dog a~~ certifying agency~~ies~~ approved by TCH**A**~~D~~.
5. Pet Therapy dogs must be wearing visible blue vests and TCH**A**~~D~~ identification name badges with their name and "Pet Therapy." Small Dogs that cannot be fitted with a vest should wear the TCH**A**~~D~~ bandana only.
6. Any problems identified with Pet Therapy pets or their handlers shall be directed to the Nursing Leadership/Charge Nurse or designee.
   a. These concerns shall be directed to the ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator at extension 7387 for follow-up and resolution.
7. Patients shall be provided with hand hygiene product to wash their hands after a visit.
8. Any handler who does not follow proper procedures or a dog that appears to be out of control will be asked to leave the hospital premises immediately with notification to the ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator~~ at extension 7387~~.
9. Dog's Equipment:
   a. Well-fitted buckle, quick-release connection, or snap closure blue collar and harness made of leather or fabric
      i. All metal/chain or slip collars may not be used.
      ii. Special training collars such as pinch, spike, electric or spray may not be used.
   b. Collars may be flat collars or Martingales (i.e. limited slip collar).
   ~~c. Halters may be Gentle Leader, Promise, Snoot Loop or Halti and may only be used at the discretion of the animal behaviorist.~~
   ~~i.~~**c.** Metal chain and retractable leashes may not be used (i.e. Flexi-Leash).
   d. Metal buckles, slip rings, and D-rings are acceptable.
   e. All leashes to be no more than 6' in length.
10. Handler's Attire:
    a. Clothing:
       i. Clothes are to be neat and tidy and may not include shorts, blue jeans, short skirts or tight-fitting clothing.
       ii. Shoes must be closed-toed.
       iii. No accessories or jewelry that may have sharp edges or corners.
    b. **TCHA** TLC Uniforms:
       i. **TCHA** TLC approved attire is to be worn by handler at all times when present in the facility on a visit with their dog.
       ii. TCH**A**~~D~~ identification (ID) badge and Pet Therapy ID badge from approved TCH**A**~~D~~ Pet Therapy certification/registration agency, both to be worn at all times.

C. **PROCEDURE:**

1. General Guidelines:
   a. All handlers must be at least eighteen (18) years of age.
   b. **TCHA** TLC is the only group sponsoring pets in the hospital that is supported by the medical staff. Dogs that have not been screened are not sponsored by **THCA** TLC in the hospital. Dogs must be at least one year of age to start in the program and have been with the handler for at least six (6) months.
   c. Handler is required to become a member of the TCH**A**~~D Auxiliary~~, which includes the following:
      i. Yearly membership dues
      ii. Background check

iii. Influenza Vaccination
iv. Tuberculosis (TB) screening
v. Hospital Orientation
vi. Annual auxiliary refresher course

d. Admittance to the TLC program requires a TCH~~AD~~ approval and supervision by ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator.
e. Health tests are required for the handler, per TCH~~AD~~ volunteer policy for health screening and dog, signed off by veterinarian, per attached form and submitted to ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator.
f. The Handler will complete a TCH~~AD~~ Pet Therapy application form and submit to the ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator, pending approved trainee status. Certification/registration documents from ~~Pet Partners, Independent Therapy Dogs, Inc., Love on a Leash or other therapy dog a~~ certifying agency approved by TCH~~AD~~ must be included with the application.
g. All trainee members (handlers and dogs) will attend an orientation meeting prior to beginning hospital work conducted by ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator:
h. Trainee handlers and their dogs should be accompanied by a certified handler and ~~Therapeutic Recreation Specialist/~~**TCHA** Pet Therapy Coordinator for a minimum of three (3) consecutive visits within 3 months of being accepted into the TLC program. Appropriateness of their behavior and awareness of TCH~~AD~~ policies will be assessed before being scheduled to make visits on their own to units. The visits will include one visit to the unit on which they will be volunteering. .
i. On a yearly basis, the dog must pass the above-mentioned physical exam for membership renewal.

2. Scheduling by the TCH~~AD~~ ~~Therapeutic Recreation Specialist/~~Pet Therapy Coordinator:
   a. Handlers will **follow TCHA policies related to volunteer hours worked**~~coordinate and schedule visits with Therapeutic Recreation Specialist/Pet Therapy Coordinator~~.
   b. Any aggressive behavior will be grounds for suspension. ~~All dogs involved may be suspended by the Therapeutic Recreation Specialist/Pet Therapy Coordinator for up to three months pending investigation. Investigation of the incident will be conducted by the Therapeutic Recreation Specialist/Pet Therapy Coordinator, Risk Management Officer and Security Staff as needed.~~ Upon investigation, the **TCHA Pet Therapy Coordinator**~~Committee~~ will determine necessary steps for further training or dismissal of the involved team from the Pet Therapy Program.
   c. Return of the team to the TLC program, will be based on assessment and training by a nationally certified dog trainer, approved by TCH~~AD~~ Pet Therapy Coordinator.

D. **REFERENCE(S):**

1. Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities. *Recommendations of CDC and the Healthcare Infection Control Practice Advisory Committee (HICPAC).* MMWR 2003; 52 (No.RR-10); 1-48.
2. Lafebre et al. (2008). *Guidelines for animal assisted intervention in health care facilities.* AJIC, 36(2). P 78-85.
3. Medical Evaluation Form for Dogs and Cats. Development, Implementation, and Evaluation of Animal-Facilitated Therapy Programs, Delta Society Conference, Oct. 4-6, 1988.
4. Pet Therapy Certification Criteria 2016
5. Proposal for Health Examination/Screening of Dogs - Pilot Pet Therapy Program. Barbara Deep, D.V.M., School of Animal Medicine, University of Washington, Oct. 1 1987. **(Rev 9/15/23)**

Tri-City Medical Center
Oceanside, California

Plan for Nursing Care

I. PURPOSE

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services (PCS) are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements per scope of service
   2. The Hospital's recruitment, retention, and staff development capabilities
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities
   4. Evaluation of innovations and improvements in patient care
   5. Affiliations, managed care contracts and reimbursement changes
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues
   7. The Hospital's Strategic and Facilities Plan and annual budget
   8. Regulatory or accreditation changes
   9. Collective Bargaining Agreement (CBA) revisions

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. DEFINITION OF NURSING

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations.

III. NURSING VISION AND DISTRICT VALUES

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City Healthcare District (TCHD).

B. The needs of our patients come first.

IV. GUIDING PRINCIPLES

A. We never lose sight of our patients' and families' needs and expectations including the need for education.

B. We strive to make the most efficient use of our resources.

C. We are alert for opportunities to improve.

D. We encourage patients and families to participate in their care and decisions affecting their care.

E. We focus on team relationships and healthy interpersonal skills.

F. We enter into partnerships with patients, families, and other health care professionals eagerly.

Department Review	Clinical Policies and Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
07/16, 06/17, 09/22, **02/24**	09/16, 07/17, 11/22, **03/24**	09/16, 07/17, 01/23, **04/24**	n/a	n/a	10/16, 08/17, 01/23, **04/24**	02/23, **05/24**	10/17, n/a	10/17, 02/23

G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at TCHD believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
   1. Caring - is the essence of nursing and is based on the care-recipient's unique needs.
   2. Diversity - is a core element for caring and leadership and address the needs of others who may have different values.
   3. Accountability - is the hallmark of professional practice~~.~~ and for adherence to organizational policy and procedure.
   4. Integrity - is the foundation for clinical practice, leadership, and learning based on adherence to the professional nursing code of ethics and professional nursing standards of practice.
   5. Advocacy - is an inherent element of nursing ethics and nursing practice to safeguard, promote, and support the patient's values and decisions.
   6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing.

VI. SCOPE OF PATIENT CARE

A. Patient care at TCHD encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers.

VII. PRACTICE STANDARDS

A. Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at TCHD to use in ethical analysis and decision-making
B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.
C. California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. TCHD nurses are responsible to be informed of these laws.

VIII. PATIENT CARE MODEL: SYNERGY™

A. TCHD Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.
B. The Synergy model delineates **the needs** or characteristics of the patients and families that influence the nurse competencies and the resources based on the patients capability for health and vulnerability to illness. ~~three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system~~.
C. Nurse Competencies:
   1. Clinical judgment, including decision making, critical thinking and basic nursing skills
   2. Caring practices
   3. Advocacy and moral agency

4. Collaboration
5. Response to diversity
6. Facilitation of learning
7. Clinical inquiry
8. Systems thinking

D. Patient Characteristics:
1. Participation in decision making about treatment options
2. Participation in care
3. Stability, ability to maintain steady-state equilibrium
4. Complexity
5. Resiliency of the patient
6. Vulnerability or susceptibility to stressors of all types
7. Resource availability
8. Predictability of the illness or injury

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:
1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
1. The RN implements the plan
2. Coordination of Care:
   a. The RN coordinates care
3. Health Teaching & Health Promotion:
   a. The RN employs strategies to promote health and a safe environment
4. Consultation:
   a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities.

B. Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.

C. Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.

D. Embraces opportunities to preceptor, mentor colleagues, and students, sharing learning to further the practice of nursing.

E. Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.

B. Each department has a staffing grid which is reviewed at as needed based on the following, including but not limited to: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized and are kept in unit/departmental documents.

XII. DELIVERY OF NURSING CARE

A. Areas where nursing care is delivered under the Division of Nursing (including but not limited to):

1. Acute Care Services (1 North, Inpatient Acute Rehabilitation [ARU], 2 Pavilion, 4 Pavilion):
   a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.
      i. 1 North: Orthopedic diagnoses are emphasized to include spine services. The plan of care is to provide high quality care for all patients to include basic musculoskeletal care to most complex joint and spinal procedures.
      ii. Inpatient Acute Rehabilitation **Unit**(ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.
      iii. 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.
      iv. 4 Pavilion: ~~Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.~~**Medical surgical diagnosis to include seizure study patients**
2. Emergency Services:
   a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.

~~3. Home Health:~~

~~a. The Home Health Department develops, implements, evaluates and executes a comprehensive care plan for patients 18 years and older who meet the criteria. The plan of care is multidisciplinary which is an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.~~

~~4.~~**3.** Infusion Center- Outpatient Hospital:

a. The purpose of this area is to meet the needs of patients who require chemotherapy, blood transfusions, antibiotic therapy, arthritic infusions, and IV infusions for dehydration.

~~5.~~**4.** Intensive Care Unit:

a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older with actual or potential life threatening medical or surgical conditions.

~~6. Neonatal Intensive Care Unit (NICU):~~

~~a. The purpose of this unit is to develop, implement, and evaluate a plan of care for infants born prematurely and/or infants who are critically ill. Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach. This plan emphasizes supportive, developmental and therapeutic care unique to the needs of each infant and includes the family and/or designated family/infant support members.~~

~~7.~~**5.** Progressive Care Unit/Specialty Clinic: **Forensic Unit**

a. This is a ~~41 bed~~ secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.

i. Continuous Cardiac Monitoring (See Telemetry: Admission and Discharge Criteria Policy)

ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)

iii. Acute rehabilitation

~~iv. Ante-partum care~~

~~v. Post-partum care~~

vi. Medical-Surgical

~~8.~~**6.** Perioperative/Perianesthesia Services:

a. Post-Anesthesia Care Unit (PACU):

i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of care to patients 14 years of age and older.

b. Pre-Operative Hold:

i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients 14 years of age and older, and **support person**~~significant others~~. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.

c. Surgery:

i. The purpose of Surgery/Operating Room is to provide surgical care to patients fourteen (14) years of age and older throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. Most surgical specialties are provided, including cardiac. There are no trauma or transplant services provided.

d. Outpatient Post-Anesthesia Care Unit:

i. The purpose of this area is to provide nursing care to patients requiring recovery from outpatient interventional procedures or stage two recovery (when needed). Nursing care is provided to deliver a safe, effective and appropriate level of patient care.

e. Preoperative Education (Outpatient Service Center):

i. The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure. Patients **will**~~may either~~ have ~~face to face visits, or~~ a telephone call for assessment and education.

~~9.~~**7.** Telemetry ~~(2 East, 2 West, 4 East, 4 West and 3 Pavilion):~~

a. The purpose of Telemetry is to develop, implement, and evaluate the plan of nursing care for all patients ~~clients~~. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, chronic mechanical ventilation, **neurological care** or patients requiring intensity of service which cannot be provided in the acute care setting.

~~10.~~**8.** ~~Women and Newborn Services:~~

~~a. The Women and Newborn Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.~~

~~11.~~**9.** Wound Care (Inpatient and Outpatient):

a. The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.

B. Areas where Nursing Care is delivered, not under the Division of Nursing:

1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.

2. Cardiac Catheterization Lab:

a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

3. Cardiac Rehabilitation:

a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.

4. Cardiovascular Health Institute:

a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.

~~5. Neurovascular Institute:~~

~~a. The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.~~

~~6. Orthopaedic Institute:~~

~~a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.~~

~~7.~~**5.** Interventional Radiology:

a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that ~~has evolved over the past 25 years to become an integral part of comprehensive nursing care,~~ provid~~esing~~ alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

A. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the Quality Assurance Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

XIV. REPORTING RELATIONSHIPS

A. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Nurse Leader. Each Director/Nurse Leader is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.

1. Staff meetings shall be conducted by the Director/Nurse Leader/designee with a mechanism established for all staff members' participation.
2. The Nurse Leader shall meet with their assigned Director/CNE at least monthly.
3. Directors/Nurse Leaders shall ensure staff communication is provided in either in shift huddles or meetings ~~are held at least monthly~~.
4. Directors/Nurse Leaders may attend the Medical Staff Division Meetings when appropriate.

B. The Chief Nurse Executive (CNE):

1. Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.

2. Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member.
3. Reports the status of the plan for Nursing Services to the Quality Committee, and to Board of Directors.
4. Attends Medical Executive as the representative for the Department of Nursing.

XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured and reported the through Quality Assurance Process Improvement committee (QAPI) and the Board annually.

XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:
   1. Patient requirements and their implications for staffing;
   2. The hospital's ability to attract and develop staff;
   3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
   4. Feedback and specific concerns raised by patients, staff, and physicians.

XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.
B. The Role of Nursing Leadership in Facilitating Excellent Nursing Care
   1. We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice.
   2. Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines ~~superb~~ competent technical skill with an expert knowledge base. The professional nurse ~~then~~ needs an outstanding ~~knack~~ skill set for communication-ease to achieve the best patient outcomes while ensuring the patient and or family needs are met.

XVIII. RELATED DOCUMENT(S):

A. Patient Care Services: Chemotherapy Administration Procedure
B. Telemetry: Admission and Discharge Criteria Policy

XIX. REFERENCE(S):

A. American Nurses Association. (2015) *Code of Ethics for Nurses with Interpretive Statements*. Washington, D.C.: American Nurses Publishing.
B. American Nurses Association. (2021) *Nursing: Scope and Standards of Practice*
C. California Nurse Practice Act (2024) https://www.rn.gov/pdfs/regulations/npr-b-03.pdf
D. ~~O'Grady, T. P. (1999) *Leading the Revolution in Health Care*. 164.~~
E. 2022. *AACN Synergy Model for Patient Care*, https://www.aacn.org/nursing-excellence/aacn-standards/synergy-model

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PRE-OPERATIVE PATIENT PREPARATION**
Purpose:	To outline the nursing care and management of patients prior to surgery.
Supportive Data:	The primary reason for pre-operative nursing care is to prepare a patient physically, psychologically, and cognitively for any impending surgery or invasive procedure. Pre-operative care is provided by the nurse at the time of the Pre-Operative Education appointment, patient's admission to the hospital and just prior to the patient's transfer to the Operating Room (OR)/Procedural Room. This procedure is intended to address the care for elective surgical patients. This procedure does not preclude the expeditious delivery of care to the patient in an emergency situation.

A. **POLICY:**

1. A physician/Allied Health Professional (AHP) order is required for all surgeries/procedures. The surgery/procedure on the consent form is transcribed from the physician/AHP order. Refer to Patient Care Services (PCS) Policy: Consent for Operative or Other Procedures for complete information regarding surgical/procedural consents.
2. Consent- forms are required to be completed for:
   a. Surgery/procedure
   b. Blood transfusion or refusal **of blood products**
   c. Anesthesia
   d. Photography
   e. Hysterectomy (when applicable)
   f. Sterilization permit (when applicable)
   g. Required documents/consents for participation in studies/trials (i.e. Intra Operative Radiation Therapy [IORT])
3. The admitting Registered Nurse (RN) shall physically assess the patient and obtain/verify the patient's past medical history ~~and~~, medication history~~.~~ **and allergies.**
4. Physician/AHP orders are required for pre-operative labs, x-ray, ECG, and diet/NPO, as applicable. Notify the physician/AHP as appropriate for significant findings, unusual patient circumstances, and signs of possible infection.
5. The patient and/or designee shall be provided with appropriate pre-operative instructions and education.
6. A ~~completed~~ Pre-Operative Checklist shall be completed prior to transfer to the Operating Room/procedure room.
7. ~~For pregnant patients, refer to PCS Policy: Pre, Intra and Post-Operative Assessment of Fetal Heart Rate (FHR) and Uterine Activity for Non-Obstetric Procedure/Surgery.~~

B. **PRE-OPERATIVE EDUCATION**

1. Pre-operative education is provided to the patient ~~at~~**during** their Pre-Operative Education appointment (outpatients) or on the nursing unit (inpatients).
2. The following information shall be included in pre-operative patient education:
   a. Surgery/procedure to be performed
   b. Instructions regarding existing implanted medical devices (when applicable)
   c. Anticipated pre-surgical routine:
      i. Signing/verification of consent forms
      ii. Completion/review of significant diagnostic tests, such as lab work, x-rays, and ECG
      iii. Diet/NPO orders and diet progression
      iv. Nasal decolonization preparation
      ~~iii.~~**v. Chlorhexidine Gluconate (CHG) skin preparation instructions**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Operating Room Committee	Pharmacy &Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
4/93, 10/09, 6/10, 03/18, **01/24**	08/11, 03/18, 08/18, 12/18, **03/24**	08/11, 09/18, 12/18, **04/24**	01/19, **04/24**	n/a	02/19, **04/24**	03/19, **05/24**	09/11, n/a	09/11, 03/19

~~iv.~~**vi.** Voiding, catheterization
~~v.~~**vii.** Intravenous (IV) initiation and purpose
~~vi.~~**viii.** Marking of surgical site by surgeon
~~vii.~~**ix.** Pre-operative medications
~~viii.~~**x.** Preparation for surgery in Pre-Operative holding area (explaining need for early arrival time)
~~ix.~~**xi.** Family waiting areas and communication with family/support persons during the perioperative period

d. Anticipated post-surgical routine:
   i. Management of pain and nausea
   ii. Vital signs
   iii. IV
   iv. Dressings, drains, tubes
   v. Activity progression (turning, splinting)
   vi. Respiratory interventions, oxygen use (coughing, deep breathing)
   vii. Communication mechanisms
   viii. Diet progression
e. Patient rights and responsibilities in:
   i. Pain management: Instruct patient regarding the various methods of pain control, analgesic administration and how to evaluate their level of pain and comfort.
   ii. Communicating symptoms, relief
   iii. Required activities (turn, cough and deep breathe, ambulation, leg exercises)
   iv. Limitations (Foley, IV, safety, bed rest)
   v. Participation in self--care (eating, toileting, hygiene)
   vi. Designated responsible adult and transportation for outpatients (refer to PCS Policy: Outpatient Post-Anesthesia/Procedure Discharge/Transportation Guidelines).

3. Review documentation for completeness including but not limited to:
   a. Surgical patient history ~~form~~ (for outpatients and AM Admits), or admission assessment/patient history ~~form~~ (for inpatients)
   b. Education ~~All Topics form~~
   c. Privacy Code information has been obtained and documented per PCS Policy: Privacy Code
   d. Medication History
   e. Preferred Pharmacy

C. **PRE-OPERATIVE PATIENT CARE**

1. Ensure completion of physician/AHP's orders for required pre-operative tests (i.e., labs, x-ray and ECG).
2. Obtain test results and notify physician(s) of abnormal results.
3. Implement gastrointestinal (GI) preparation and dietary changes as ordered (i.e., bowel prep or NPO).
4. Chlorhexidine Gluconate (CHG) Instructions
   a. Inpatients: Implement the pre-operative shower/bath regimen and skin preparation using Chlorhexidine Gluconate (CHG) wipes, unless otherwise ordered by physician:
      i. The night prior to surgery, have the patient shower (or assist with bed bath) using warm (not hot) water and regular soap and shampoo, at least one hour before using the CHG wipes. Thoroughly wash the proposed incision site and surrounding area. Dry with a clean towel.
      ii. Do not shave the area of the proposed surgical incision for at least two days before surgery, unless ordered by the physician (if hair removal is ordered, use surgical clippers). Do not shave anywhere on the body from the neck down before using CHG, as this may increase risk of sensitivity to CHG.

iii. Skin preparation with CHG wipes shall be repeated the morning of surgery (or within four hours prior to surgery for scheduled afternoon/evening cases or add-on procedures).
1) For inpatients and admissions from the Emergency Department, the CHG skin preparation shall be performed in the patient's respective unit prior to being transported to surgery.
iv. Allow skin to dry and cool completely before applying CHG wipes.
v. Perform pre-operative skin preparation with CHG wipes.
~~1) Open all three packages of wipes and transfer the contents onto a clean prep table. Each package contains two wipes. Discard the blue foam pad from each package.~~
~~2)~~**1)** Use one cloth to prep each of the following areas of the body (a total of six cloths will be used for the skin preparation):
a) Left arm
b) Right arm
c) Left leg and foot (front and back)
d) Right leg and foot (front and back)
e) Chest and abdomen
f) Back, from base of neck to buttocks
~~3)~~**2)** Discard each cloth after single use and discard any unused cloths after the package has been opened.
a) Do not flush wipes down the toilet.
~~4)~~**3)** Supply patient with a clean gown and clean bed linens after the CHG skin preparation has been completed.
~~5)~~**4)** If on a monitored unit, do not place electrodes on or near the surgical site.

b. Outpatients are instructed on the pre-operative skin preparation process during their Pre-Operative Education appointment. Outpatients are to take a shower with CHG solution at home the night before and the morning of surgery.
i. Patients undergoing head or neck surgery should be instructed to shampoo their hair prior to surgery.
ii. For outpatients and AM Admits, skin preparation with CHG wipes will be performed in Pre-Operative Hold area prior to surgery.

c. Do not use CHG wipes on:
i. Patients scheduled for cesarean delivery or post-partum tubal ligation
ii. Breast feeding women undergoing non-obstetrical procedure(s)
iii. Premature or low birth weight infants
iv. Infants receiving phototherapy
v. Children less than two months old
vi. Patients with known allergies to CHG
vii. Lumbar punctures or in contact with the meninges
viii. Open skin wounds
ix. Eyes, ears, mouth, face, hair or genital area
x. When applied to sensitive skin, CHG may cause skin irritation such as temporary itching sensation and/or redness. If irritation persists or rash or hives occur, rinse affected areas and discontinue use.

d. Do not shower, bathe, or apply any lotions, powders, cosmetics, or creams on the patient's skin after using the CHG wipes.

e. Once the patient is prepped with the CHG wipes, ensure the product has dried before placing them under a warm blanket or forced air warming device. Heat will open the pores allowing the solution to penetrate the skin deeper than necessary, which can increase risk of skin irritation.

5. For all elective surgeries, the following guidelines are recommended:
a. Patients should be NPO prior to surgery for:
i. Two (2) hours after clear liquids

ii. Eight (8) hours after solids

b. Oral medications may be taken with small amounts of clear liquids (Outpatients, refer to PCS Standardized Procedure: Pre-Operative Medication Instructions to Surgical Patients).

c. Placement of a naso-gastric tube does not affect the above criteria.

d. For all emergency operations in which the above criteria are not satisfied, the surgeon must document in the patient's chart that the case is an emergency prior to the administration of anesthesia.

D. **DAY OF SURGERY/PRIOR TO TRANSFER**

1. Pre-operative and surgical/procedural RNs review the chart for completeness, including:
   a. Pre-operative orders
   b. Pre-operative test results
   c. Necessary consent forms
   d. History and Physical (H&P) **within 30 days**
   ~~e. Physician Pre-Procedure Documentation form~~
   e. Surgeon Interval Update on day of surgery
   f. Request for Services form (for Justice Involved Individuals)
   g. Privacy Code information has been obtained and documented per PCS Policy: Privacy Code
   h. Completed admission assessment/patient history ~~form~~ (inpatients) or surgical patient history ~~form~~ (outpatients and AM Admits)
   i. Medication History
   j. Pain Target Level has been determined and recorded in the Pain Assessment
   k. Pre-Operative/Pre-Procedure checklist (including disposition of patient belongings)
2. Assess patient's physical, psychological, and cognitive readiness for surgery:
   a. Perform baseline physical assessment and vital signs as appropriate
   b. Review aspects of pre-op education as needed
3. On the day of surgery, a pre-operative urine HCG is required for all women age 55 and under, except patients with documented hysterectomy, bilateral tubal ligation, bilateral tubal occlusion, or bilateral oophorectomy.
   a. Contact physician/AHP for urine HCG order if not already ordered.
   b. HCG results for inpatients are accepted up to one day prior to surgery. If urine HCG result was obtained greater than one day prior to surgery, a new test is required.
4. Reportable Conditions
   a. Report to the physician/AHP::
      i. Incomplete physician/AHP pre-operative orders
      ii. Abnormal test/lab results not noted to have been reported to primary surgeon
      iii. Evidence of significant findings in review of systems
      iv. Unusual patient circumstances, such as excessive anxiety or fear, voicing abuse, etc.
      v. Incomplete physician/AHP documentation
      vi. Incorrect/unsigned consent forms
5. Initiate IV therapy and give pre-operative medications as ordered.
   a. Assure on-call antibiotics accompany the patient for administration in the OR, unless antibiotic to be initiated in Pre-Op Hold.
   b. Do not initiate on-call pre-operative antibiotic infusion on patient care floor/unit (must be started within 60 minutes prior to incision time). Continue existing scheduled antibiotic regimen if dose is due pre-operatively. If scheduled dose will be due during patient's time in OR, send the antibiotic for administration peri-operatively.
6. Remove all personal items (i.e. prosthetics, jewelry, piercings, eyeglass, hearing aids and dentures).
7. If the patient has valuables, refer to PCS Policy: Patient Valuables Liability and Control

8. Prior to leaving the pre-operative/pre-procedure area, verify that the physician/AHP has marked the correct surgical site when applicable. Refer to PCS Procedure: Universal Protocol for complete procedural verification and site marking information.
9. Have patient void on call to the OR, if appropriate.
10. Complete preparation of patient according to physician's orders and to Pre-Operative/Pre-Procedure checklist prior to scheduled surgery time.
11. Inform family/designee of patient going to the OR and guide him/her to waiting area on the first floor.
    a. Verify and document in the Pre-Operative/Pre-Procedure checklist the contact information (name, relationship, phone number and location during surgery) of the responsible person.
12. Review documentation for completeness including but not limited to:
    a. Pre-operative/pre-procedure checklist
    b. Vital signs
    c. Pre-Operative Systems Assessment (for outpatients and AM Admits)
    d. Medications administered
    e. Complete Medication History (including last dose of medications)
    f. Disposition of patient belongings
    g. Patient education
    h. Privacy Code information has been obtained and documented per PCS Policy: Privacy Code (if not already completed)

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

1. PCS Policy: Consent for Operative or Other Procedures
2. PCS Policy: Outpatient Post-Anesthesia/Procedure Discharge/Transportation Guidelines
3. PCS Policy: Patient Valuables Liability and Control
4. ~~**PCS Policy: Pre, Intra and Post-Operative Assessment of Fetal Heart Rate (FHR) and Uterine Activity for Non-Obstetric Procedure/Surgery**~~
5. ~~4.~~ PCS Policy: Privacy Code
6. ~~5.~~ PCS Procedure: Universal Protocol
7. ~~6.~~ PCS Standardized Procedure: Pre-Operative Medication Instructions to Surgical Patients

F. **REFERENCE(S):**

1. Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.
2. Manufacturer's Instructions; 2% Chlorhexidine Gluconate Cloth Patient Pre-Operative Skin Preparation. ~~SAGE Products, Inc. Retrieved from www.sageproducts.com March 5, 2018~~**Medline Ready Prep CHG wipes. Retrieved from LIT176_PST_ReadyPrep CHG_19W1336015.pdf (medline.com) January 3, 2024**.
3. Schick, L & Windle, P. E. (2016). *PeriAnesthesia Nursing Core Curriculum.* (3rd ed.). St Louis, MO: American Society of PeriAnesthesia Nurses.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/13

SUBJECT: Specimen Transport to TCMC Main ~~Hospital~~ Laboratory from Off-Site Facilities

REVISION DATE~~(S)~~: 10/17

Patient Care Services Content Expert Approval	**~~03/20~~02/23**
Clinical Policies and Procedures Approval:	**~~05/20~~04/23**
Nursing Leadership Approval:	**~~06/20~~05/23**
Department of Pathology Approval:	**~~09/20~~03/24**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/20~~04/24**
Administration Approval:	**~~10/20~~05/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/20**

A. **PURPOSE:**
1. To protect the integrity of all laboratory specimens and to ensure accuracy of results, specimens collected at off-site facilities must be transported in a timely manner as mandated by the hospital's laboratory policies.

B. **POLICY:**
1. All specimens will be delivered to the laboratory as prescribed by laboratory policy.
2. In the event that a specimen cannot be transported in the prescribed time period, the laboratory will be contacted for assistance to accomplish transport.

C. **PROCEDURE:**
1. When collecting specimens, clinic staff will wear, at a minimum, exam gloves. If soiling or splattering is likely, the proper personal protective equipment will be utilized during the specimen collection procedure.
2. All specimens are collected following specific laboratory procedures.
3. Labeling
   a. Refer to the Patient Care Services Specimen Labeling Procedure
4. Specimens will be placed in plastic sealed biohazard bags with the appropriate request form secured to the outside.
5. Specimens will be brought to the laboratory within the timeframe designated by the hospital laboratory.
6. The laboratory will notify the clinic when specimens are not acceptable.
   a. The clinician will notify the physician for further orders.

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

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SURGICAL HAND ANTISEPSIS**
Purpose:	To outline the steps to effectively perform surgical hand antisepsis
Supportive Data:	The goal of surgical hand antisepsis is to remove soil and transient microorganisms from the hands of perioperative team members and suppress the growth of resident microorganisms for the duration of the surgical procedure to reduce the risk that the patient will develop a surgical site infection (SSI). Surgical hand antisepsis is the primary line of defense to protect the patient from pathogens on the hands of scrubbed team members, whereas sterile surgical gloves are the secondary line of defense. Safe and effective surgical hand antisepsis rapidly and persistently removes transient microorganisms and suppress the growth of resident microorganisms with minimal skin and tissue irritation.

A. **DEFINITIONS:**

1. Surgical Hand Antisepsis: Hand wash or hand rub using a surgical hand antiseptic, performed preoperatively by the surgical team to remove transient flora and reduce resident skin flora.
2. Surgical Hand Antiseptic: A product that is a broad-spectrum, fast-acting, and nonirritating preparation containing an antimicrobial ingredient designed to significantly reduce the number of microorganisms on intact skin. Surgical hand antiseptic agents demonstrate both persistent and cumulative activity.

B. **POLICY:**

1. Surgical hand antisepsis shall be performed prior to donning sterile gowns and gloves for operative or other invasive procedures.
2. All personnel who perform surgical hand antisepsis shall maintain healthy fingernail and hand skin condition. **(see Patient Care Services [PCS] Policy Surgical Attire)**
3. Take measures to prevent hand dermatitis, including:
   a. Use moisturizing skin care products approved by Tri-City Medical Center (TCMC).
   b. Completely dry hands before donning gloves.
   c. In the absence of visible soil, disinfect hands with an alcohol-based hand rub rather than washing with soap and water.
   d. If necessary, sterile cotton glove liners may be worn under sterile gloves. Single-use cotton glove liners shall be discarded after each use.
4. Personnel with breaks in skin integrity shall not scrub.

C. **PREPARING TO SCRUB:**

1. Personnel shall don surgical attire prior to beginning surgical hand antisepsis (see Patient Care Services [PCS] Policy Surgical Attire).
   a. The scrub shirt should be tucked into pants or fit snugly to the body.
   b. All jewelry must be removed or confined within the surgical attire. Hand and wrist jewelry may not be worn.
2. Don fresh surgical mask and adjust snugly over nose and mouth.
3. Don protective eyewear, unless eye protection is integrated into mask or user will be wearing an orthopedic hood.
4. Inspect hands and forearms:
   a. Fingernails shall be maintained short and natural.
      i. In addition to Administrative Policy: Dress and Appearance Philosophy - 415, fingernails should be short (less than 2mm or 0.08") and in good repair. Nail jewelry, artificial nails, nail extenders, nail wraps or any other nail treatments are

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Operating Room Committee	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/12, 07/18, 04/20, **06/23**	12/12, 08/18, 09/20, **07/23**	09/18, 10/20, **08/23**	**07/18, 06/20, 02/24**	10/18, 10/20, **03/24**	n/a	01/13, 10/18, 11/18, 11/20, **04/24**	01/19, 12/20, **05/24**	02/13, n/a	02/13, 01/19, 12/20

not allowed. ~~If nail~~**Nail** polish ~~is~~ **and gel polish shall not be** worn~~, it must be free of chips or peeling~~ **by scrubbed personnel**.

D. **SURGICAL HAND ANTISEPSIS WITH APPROVED SURGICAL HAND SCRUB:**

1. Surgical hand antisepsis using a surgical hand antiseptic scrub should be performed according to manufacturer's instructions for use (IFU).
2. If hands are visibly soiled, wash hands with soap and water.
3. Remove debris from underneath fingernails using a disposable nail cleaner under running water.
4. Apply the amount of surgical hand scrub product recommended by the manufacturer to the hands and forearms using a soft, nonabrasive sponge. A commercially prepared, pre-moistened surgical scrub sponge with approved surgical scrub agent may be used.
   a. Do not perform the surgical hand scrub using a brush, which may damage skin and increase the amount of bacteria shedding from the hands.
5. Visualize each finger, hand, and arm as having four sides. Wash all four sides effectively, keeping the hands elevated.
6. Scrub for length of time recommended by the manufacturer. The scrub should be timed to allow adequate product contact with the skin.
7. For water conservation, turn off water when it is not in use, if possible.
8. Avoid splashing surgical attire.
9. Discard sponge, if used.
10. Rinse hands and arms under running water in one direction from fingertips to elbows.
11. Hold hands higher than elbows and away from surgical attire.
12. In the OR or procedure room, dry hands and arms with a sterile towel (drying from fingertips to elbow, while bending forward at the waist) using sterile technique before donning a surgical gown and gloves.

E. **SURGICAL HAND ANTISEPSIS USING APPROVED SURGICAL HAND RUB:**

1. Perform surgical hand antisepsis using a surgical hand antiseptic rub according to the manufacturer's IFU.
2. If hands are visibly soiled, wash hands with soap and water.
3. Remove debris from underneath fingernails using a disposable nail cleaner under running water.
4. Rinse hands and forearms under running water and dry hands and forearms thoroughly with a disposable paper towel.
5. Apply the surgical hand rub product to the hands and arms according to the manufacturer's IFU, including amount of product to be dispensed for each use, method of application, and time.
6. Allow hands and arms to dry completely before donning gown and gloves, per manufacturer's IFU. Do not dry with a towel.

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

1. Administrative Human Resources Policy: Dress and Appearance Philosophy 8610-415
2. Tri-City Healthcare District Approved Surgical Scrub Products
3. **Patient Care Service Policy: Surgical Attire. Tri City Medical Center, 6/2023.**

G. **REFERENCE(S):**

1. ~~AORN, Inc. (2020).~~ **Hand Hygiene,** Guidelines for Perioperative Practice. Denver, **CO., AORN INC., 2023 269-307**.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/16

SUBJECT: Wound Classification During Surgical Intervention

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

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

A. **PURPOSE:**
1. To classify all wounds according to the likelihood and degree of wound contamination at the time of surgical intervention.

C. **POLICY:**
1. Wound classification shall be reviewed at the conclusion of the procedure and documentation of wound classification shall be updated as necessary.
2. The following criteria shall be used to classify surgical wounds:
   a. Clean Wound, Class I
      i. Clean, un-infected operative wounds in which no inflammation is encountered.,
      ii. Procedures are free from entry into respiratory, alimentary, or genitourinary tract.
      iii. Wounds are primarily closed, and if necessary, drained with closed drainage (e.g., bulb drain).
      iv. Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.
   b. Clean-Contaminated Wound, Class II
      i. Respiratory, alimentary, or genitourinary tract is entered under controlled conditions without evidence of infection or contamination, and with no major breaks in technique (e.g., spillage from gastrointestinal tract).
   c. Contaminated Wound, Class III
      i. Wounds are fresh, open, or accidental, or there is gross (i.e., visible) spillage from the gastrointestinal tract, or there is acute non-purulent inflammation present.
      ii. Major breaks in sterile technique (e.g., unsterile instruments used) during the procedure.
   d. Dirty and Infected Wound, Class IV
      i. Old wounds with retained, devitalized tissue (i.e., gangrene, necrosis)
      ii. A wound with existing clinical infection (e.g., purulence)
      iii. A perforated viscera
   e. No Wound Classification
      i. There is no wound, including, but not limited to procedures such as closed reductions (with no break in skin integrity), and examination under anesthesia (EUA).

D. **REFERENCES:**
1. AORN, Inc. (2023). *Guidelines for Perioperative Practice.* Denver.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 5/04

SUBJECT: Notification to Pre-Hospital Personnel; Exposure to Infectious Disease

REVISION DATE: 7/04; 12/05; 06/09

POLICY NUMBER: 8610-530

Administrative Content Expert Approval:	~~05/20~~03/23
Administrative Policies & Procedures Committee Approval:	~~05/20~~04/23
Organization Compliance Committee Approval:	~~09/20~~03/24
Infection Control Committee Approval:	03/24
Medical Executive Committee Approval:	~~01/17~~ n/a
Administration Approval:	~~10/20~~05/24
Audit, Compliance and Ethics Committee Approval:	n/a
Board of Directors Approval:	11/20

A. **PURPOSE:**

1. Both federal and California law establish requirements for reporting exposures of pre-hospital emergency medical personnel to certain infectious diseases.

B. **DEFINITIONS:**

1. Pre-hospital emergency medical care personnel may include: Paramedic, Registered Nurse (RN), Emergency Medical Technician (EMT), lifeguard, fire fighters, peace officers, federal officers, volunteers, and physicians who provide pre-hospital emergency medical care or rescue services.
2. Reportable disease or condition means those diseases listed in Section I and prescribed by Title 17, CCR Sections 2500-2640 and Title 8, CCR Section 5199 Appendix A.
3. Mobile Intensive Care Nurse (MICN): a Registered Nurse specialized in pre-hospital care. The MICN works with medics, EMTs, and pre-hospital staff to provide patient care while following San Diego protocols.

C. **CALIFORNIA REPORTING LAW:**

1. Under specified circumstances, pre-hospital emergency medical care personnel exposed to a person afflicted with a disease or condition listed as reportable and transmitted through oral contact or secretions of the body must be notified that they have been exposed to a disease as defined in Section I [Health and Safety Code Section 1797.188
2. Notification of exposure: The pre-hospital emergency medical care person who provided services must give their name and phone number to the Tri-City Medical Center (TCMC) Base Hospital Coordinator (MICN) at the time patient is transferred from their care to the admitting health facility. Pre-hospital emergency medical care persons may also give their name and phone number to the transporting party to relay to the hospital.
3. The TCMC Base Hospital Coordinator, MICN, or Emergency Department **Nurse Leader**~~Charge nurse~~ facilitates the completion of the County of San Diego Communicable Disease Exposure Report. The report is then forwarded to the Infection Control department. The Base Hospital Nurse Coordinator will follow up with the EMS Coordinator/Infection Control Officer of the appropriate EMS agency.
4. Exposed personnel arriving at TCMC are directed to Occupational Health/Emergency Department for evaluation and treatment.
5. If the exposed personnel do not arrive at TCMC, the TCMC Base Hospital Coordinator or MICN must report the name(s) and telephone number(s) to the county health officer, as soon as the patient is diagnosed with a reportable disease or condition. The phone number to call is 619-515-6620 (San Diego County Community Epidemiology Branch).

6. The County Health Officer is then responsible for informing the involved pre-hospital emergency medical care personnel of the exposure. The statute does not provide for any release of information from hospitals to pre-hospital emergency medical care personnel.
7. Furnish other pertinent information related to the occurrence as may be requested by the local health officer or CDPH.

D. **FEDERAL LAW:**

1. The Ryan White Comprehensive AIDS Resources Emergency Care Act, requires medical facilities to give a report to the "designated officer" (DO) of the pre-hospital emergency response service when personnel are exposed to specified infectious diseases (see Section I for list of diseases) during the transport of a patient to the hospital. The TCMC Base Hospital Coordinator or designee maintains a current list of facilities and designated officers.
2. The hospital is responsible for initiating reports only regarding infectious pulmonary tuberculosis. Reports regarding questions about all other infectious conditions (i.e. Hepatitis B, HIV infection (including AIDS), Diphtheria, Meningococcal disease, Plague, Hemorrhagic fevers (ex. Lassa, Marburg, Ebola, Crimean-Congo), Rabies, and others yet to be identified) will be initiated by the DO of the pre-hospital emergency response service.

E. **SCOPE OF RESPONSIBILITY:**

1. The duties of Tri-City Healthcare District terminate upon discharge of the patient for conditions arising from the emergency or at the end of the 60-day period (beginning on the date the victim is transported by the emergency response employee to the hospital), whichever period is shorter. A response must be made as soon as possible but not later than 48 hours after the request is made.
2. This time period can be extended to a maximum of 90 days if the request for information is received within 30 days of the applicable 60-day period.
3. The Ryan White Comprehensive AIDS Resources Emergency Care Act does not authorize or require a facility to test any patient for any infectious disease.
4. The Ryan White Comprehensive AIDS Resources Emergency Care Act A does not authorize or require any facility, designated officer or emergency response employee to disclose identifying information with respect to a patient or an emergency response employee.
5. The designated officer and any emergency response employee to whom disclosure is made must maintain the confidentiality of HIV test results and may be personally liable for unauthorized release of any identifying information about the HIV results.

F. **EVALUATION:**

1. TCMC receives by mail, fax, phone, or in person a request from the DO for information about possible exposure to one of the above infectious diseases.
2. These are all referred to and evaluated by the TCMC Base Coordinator.
3. After hours and on weekends, the ED "Radio Nurse" will review the request.
4. If the request is made without a Confidential Morbidity Form, one is completed by the TCMC Base Coordinator or "Radio Nurse" to gather appropriate information.
5. Infection Control can be contacted for assistance.
6. One of the following determinations is made:
   a. The pre-hospital emergency medical personnel were exposed.
   b. The pre-hospital emergency medical personnel were not exposed.
   c. Facts about the case are insufficient to determine an exposure.
7. Infection Control will notify TCMC Base Coordinator of potential exposure if a patient was transferred via ambulance/EMS.

G. **RESPONSE:**

1. All requests must be answered and shall be made in writing **as soon as possible** (ASAP) but no later than 48 hours after receiving the request. The response will be sent by fax whenever possible. The information provided to the DO will include the name of the infectious disease, the date the patient was transported and the run number of the EMS call.
2. If a response is sent by mail, the DO will be notified by telephone that the response has been

sent. The DO, within 10 days, must inform the facility whether the notification has been received.

3. The local public health officer will be contacted when:
   a. The hospital reviewer is unable to make an independent determination that the pre-hospital emergency medical personnel were exposed to a reportable disease or condition.
   b. The public health officer will resubmit the request to TCMC after evaluation. TCMC staff will make the follow-up report to the DO.
4. If the patient dies and a different facility is responsible for determining the cause of death, a copy of the request will be sent to that facility for the follow-up.

H. **CONFIRMED AIRBORNE DISEASES:**

1. If a patient is transported by pre-hospital emergency medical personnel to TCMC and is determined to have infectious pulmonary tuberculosis, the Infection Control Practitioner or designee will send a notice to the DO of the Emergency Medical Service that transported the patient.
2. This notice shall be made as soon as is practicable, but no later than 48 hours after a positive Mycobacterium tuberculosis culture is obtained or notification of a positive culture is received from San Diego Health and Human Services TB Control Program.
3. Notice will include the date, run number, and infectious disease involved.

I. **REPORTABLE DISEASE LIST, TITLE 17, CALIFORNIA CODE OF REGULATIONS, SECTION 2500:**

1. The following communicable diseases can be transmitted through oral contact (for example mouth to mouth respirations) or by mucus membrane or non-intact skin contact with secretions (including blood) from the patient.
   a. Acquired Immune Deficiency Syndrome (AIDS)
   b. Diphtheria
   c. Human Immunodeficiency Virus infection (HIV)
   d. Hepatitis, Viral
   e. Invasive Group A Streptococcal Infection
   f. Leprosy (Hansen Disease)
   g. Measles (Rubella)
   h. Meningococcal Infections *(Neisseria meningitidis)*
   i. Mumps
   j. Pertussis (Whooping cough)
   k. Plague, Pneumonic
   l. Poliomyelitis, Paralytic
   m. Rabies
   n. Rubella (German Measles)
   o. Tuberculosis
   p. Viral Hemorrhagic Fevers (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
   q. Anthrax
   r. Botulism (infant, food-borne, wound, other)
   s. Cholera
   t. Food-borne Disease
   u. Smallpox

J. **REFERENCES:**

1. California Healthcare Association Current Consent Manual
2. Title 22, California Code of Regulations, Section 70737 (General Acute Care Hospital) and 71535 (Acute Psychiatric Hospital).
3. https://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf
4. https://www.dir.ca.gov/title8/5199a.html
5. http://www.dir.ca.gov/title8/5199.HTML
6. Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Ryan White Care Act, Ryan White, Pub.L. 101-381, 104 Stat. 576, enacted August 18, 1990)

7. Title 8, CCR Section 5199 Appendix A

RETIRE – no longer using Nurse Practitioner in Cardiology

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Cardiology Standardized Procedures

Approvals

Cardiology Division (Signature):	~~June 2, 2021~~January 3, 2024
Medicine Department (Signature):	~~March 17, 2021~~ n/a
Interdisciplinary Practice Committee (Date):	~~July 19~~, ~~2021~~April 15, 2024
Medical Executive Committee (Date):	~~September 27, 2021~~April 22, 2024
Administration (Date):	~~October 19, 2021~~May 21, 2024
–	
Professional Affairs Committee (Date):	n/a
Board of Directors (Date):	October 26, 2021

NURSE PRACTITIONER STANDARDIZED PROCEDURES

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I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.

2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

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

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Cardiology NP will:

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

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

b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.

c. Order medications as included in the Cardiology division Cerner Power Plans.

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

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

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

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

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

f. Order and interpret specific laboratory studies for the patient as included in the Cardiology division Power Plans.

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

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

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

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

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

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

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for the Cardiology Division are as follows:

i. CARD ACS, CP, CAD

ii. CARD CHF Beta Blockers and Calcium Channel Blockers

iii. CARD Cath Lab PTCA Stent

iv. CARD Cath Lab Post Procedure

v. CARD Cath Lab Pre Procedure

vi. CARD Elective Cardioversion Post

vii. CARD Elective Cardioversion Pre

viii. CARD Heart Failure

ix. CARD Integrilin

x. CARD Post Cath Lab Teach (subphase)

xi. CARD Transesophageal Echocardiogram PRE

xii. CARD Pericardiocentesis

III. MANAGEMENT OF CONTROLLED SUBSTANCES

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

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

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

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

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

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

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

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

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

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

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

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

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

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

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

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

VI. QUALITY IMPROVEMENT

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

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

VII. Practice Prerogatives

A. As determined by the NP – Cardiology and the NP Cardiovascular Health Institute Card.

Acknowledgement Statements:

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

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

Nurse Practitioner Signature Date

Supervising Physician Signature Date

Supervising Physician Signature Date

Supervising Physician Signature Date

Supervising Physician Signature Date

Supervising Physician Signature Date

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/95**	**SUBJECT:**	**Aerosol Transmissible Diseases and Tuberculosis Control Plan**
REVISION DATE:	**09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16, 01/17, 02/18, 09/18, 08/19, 09/20, 02/23**		

Infection Control Department Approval:	**~~11/22~~01/24**
Infection Control Committee Approval:	**~~12/22~~03/24**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/23~~04/24**
Administration Approval:	**~~02/23~~05/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/23**

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:**

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) to provide care to patients with ATDs with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Source Control Procedures including cough etiquette / respiratory hygiene.
   b. Implementation of an effective triage system and early identification of suspects and active cases
   c. Engineering control measures
   d. Respiratory protection programs
   e. Education and training of employees
   f. Evaluation and treatment of employees exposed to ATDs
   g. Protection of patients, employees and visitors from exposure to ATDs. These include:
      i. Pathogens requiring Airborne Precautions;
      See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
      ii. Diseases requiring Droplet Precautions;
      See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
      iii. Ebola disease: Requires special considerations: Please see Infection Control Ebola Plan policy for management of a patient with suspected or confirmed Ebola. *Requires a negative pressure room.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the

facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATDs and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.

~~a.~~**b.** **Infection Preventionists are responsible for conducting investigation of non-employee (e.g. visitors, patients, vendors, etc.) exposures to ATDs and TB. Exposed will be notified via phone call and certified letter as soon as exposure and contact tracing is confirmed. Exposed non-employees are responsible of following up with their PCP's, their nearest community health service center or an SDPH Tuberculosis clinic, for screening, testing and evaluation of TB disease risk.**

~~b.~~**c.** The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.

~~c.~~**d.** Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATDs and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling staff who have active ATDs. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.

~~d.~~**e.** Department Directors and Managers are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; .

~~e.~~**f.** Administrative Supervisor is responsible for patient placement in a negative pressure room.

~~f.~~**g.** Case Management reports to the County TB Control for suspected and confirmed TB cases, during the weekdays, weekends and holidays.

~~g.~~**h.** The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATDs.

~~h.~~**i.** The Manager of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATDs.

~~i.~~**j.** The Facilities Manager is responsible for monitoring and verifying air pressures daily on Airborne Infection Isolation Rooms (AIIR), when in use, and reporting of air changes and air pressures to the Infection Control and Safety committees annually.

~~j.~~**k.** The Manager of Pulmonary Services is responsible for training, implementing and monitoring respiratory staffs' adherence to the ATD and TB Control plan including protection for high-hazard procedures.

~~k.~~**l.** The Facilities Manager is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.

~~l.~~**m.** Microbiology Supervisor is responsible for the notification to the local health authority according to California and Federal regulations of ATDs and TB.

~~m.~~**n.** The Employees are responsible for early identification of suspects and active cases of ATDs and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review report.

~~n.~~**o.** The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.
iii. Treat all highly suspected tuberculosis cases with anti-tuberculosis medications pending sputum results.
iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.
v. Implement control measures when ATD is suspected.

E. **AVAILABILITY OF THE PLAN:**

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual for all staff. . OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. **FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:**

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
   a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
   b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
   c. The final and least effective control is the use of respiratory protection.

G. **TUBERCULOSIS RISK ASSESSMENT:**

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
   a. Community TB profile from public health department data
   b. Number of infectious TB patients treated in outpatient and inpatient areas.
   c. Drug susceptibility patterns of TB patients
   d. Analysis of staff PPD test results by area
   e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
   f. Observation of practice and review of engineering controls.
2. Considerations for determining the hospital's risk classification will be based on the following:

VERY LOW RISK	There are no TB patients admitted to the facility during the preceding year
LOW RISK	The employee PPD conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis

	Fewer than 6 patients were admitted to area during the preceding year There is no evidence of person-to-person transmission No clusters of staff PPD conversion
INTERMEDIATE RISK	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
HIGH RISK	PPD conversion rate is higher in areas without occupational exposure to Tuberculosis. Clusters of staff PPD conversion. Evidence of person-to-person transmission. More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejuno-ileal bypass surgery, >10% below body weight, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff can obtain a HEPA filter (recirculator) from the Engineering department to enhance circulation in the exam or treatment room. Contact Engineering for placement assistance. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
   a. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this area.
   b. If the patient is suspected or known to have infectious TB, the room must remain vacant per **Section M: Room Shut Down Time**. The door is to remain closed and the filter running.
   c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a surgical mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior to transporting the patient to those areas.

9. Patients seen in the ED with confirmed or suspected pulmonary TB are masked and placed in C-26, a negative pressure room. Staff must wear an N95 respirator when entering the room.
   a. These patients might require hospitalization to control the spread of infection. Patients confirmed or suspected with pulmonary TB, will be masked if transporting throughout the facility.

H. **MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:**

1. Staff who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an AIIR (i.e. negative pressure room: C-26, 143, 243, 287, 387, 443, 487, Maternal Child room 200, 201and Progressive Care Unit (PCU) Rooms 301, 312 and 326,) The door must be closed . Post the Airborne Precautions sign outside the room.
3. If a negative pressure room is not available, Administrative Supervisor of the need for an Airborne Precautions room. Contact Engineering for a HEPA filter for the current room, until a negative pressure room is available. Keep the door closed and post the Airborne Precautions sign. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this room. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
4. Cohorting TB patients:
   a. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
5. Reporting:
   a. The Unit Secretary notifies Engineering (by placing a worker order) that an Airborne Precautions room is in use for tuberculosis.
   b. On weekends and holidays, the Case Manager will notify the County Public Health TB Control by calling phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
   c. Laboratory Results: Hospitals and staff are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
   d. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures are sent to Public Health TB Control.
   e. The Infection Preventionist (x 5696) or designee is responsible for reporting to public health. County Public Health TB program nurses are available 8:00am to 5:00pm, 7 days a week and all holidays at (619) 540-0194. TB Control does not have personnel available between the hours of 5:00 pm and 8:00 am. Persons with routine questions about TB exposure should call (619) 692-8610 after 8:00am on the following day.
   f. To report a case of TB after 5:00pm do one of the following:
      i. Call pager (619) 540-0194 after 8:00 am the following day to report directly to TB Control RN if they feel there is urgency about reporting; or
      ii. Leave a message on the TB Control RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.
   g. Persons requesting Discharge Approval should:
      i. Contact TB Control RN between 8:00am and 5:00pm
   h. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5:00pm, should do the following:
      i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.

ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB Control RN on phone number (619) 692-8610 after 8:00am on the following day.

i. Persons calling about patients who are leaving against medical advice (AMA):
   i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
   ii. Call intake RN between 8:00am and 5:00pm; after hours call 8:00am the next day

6. Staff (fit-tested and approved for use) will wear an N95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health & Wellness Policy Manual.
7. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
8. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and when the areas are less crowded.
9. Limit the number of persons entering an isolation room to a minimum. All visitors (except staff who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
10. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
11. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
    a. The patient is in an Airborne Precautions room.
    b. The portable air filtration system has been set-up in a regular room.
12. Staff must wear respiratory protection (N95 respiratory or Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who are being ruled out for Tuberculosis. See High Hazard Procedures.
13. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until they are outside of the hospital.
14. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Staff entering the room before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.
15. Bronchoscopy considerations
    a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever performed on a suspect TB patient. Respiratory protection must be worn. An N95 Respirator or Powered Air Purifying Respirator-PAPR must be worn by staff performing a Bronchoscopy on a suspect TB patient. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:

1. Surgery/Peri-Anesthesia Nursing Services
   a. Postpone non-urgent or elective procedures on suspected/confirmed TB patients until the patient is no longer infectious.
   b. If procedures must be performed, they should be done in OR rooms with door closed

and traffic at a minimum.

c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.
d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.
e. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR). Order PAPRs from SPD (xt 7728)
   i. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.
f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).
g. Airborne Precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.

2. Home Health Services
   a. Staff entering the home of a patient with confirmed or suspected TB or ATD should wear appropriate respiratory protection.
   b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.
   c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
   d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
   e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). Staff will wear respiratory protection during the procedure
   f. Specific processes and procedures pertaining to ATDs in the home are found in the Home Health Care policy manual.

J. **DIAGNOSTIC EVALUATION:**

1. Diagnostic evaluation should include the following:
   a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.
   b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.
   c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.
   d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.
   e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL).Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.
   f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.
   g. Drug susceptibility should be performed on all initial isolates from patients with TB.

h. Contact Infection Prevention at Ext. 5696 for the latest recommendations.

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL or when another diagnosis is confirmed
2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. TB Control can be contacted at: 619-692-8610 or 619-540-0194.
   a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:
      i. The Department of Health TB Control to the specific county in which the justice involved patient is residing.
      ii. The Public Health Department of the prison.
   b. For all other inpatient units:
      i. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.
      ii. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.
      iii. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.
      iv. Placement into case management (e.g. DOT) or outreach programs of the public health department.
      v. The charge nurse, patients nurse or Case Manager, will notify the Public Health TB Control Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.
      vi. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194
2. Cleaning of the room after a known or suspected TB patient is moved or discharged:
   a. If the suspected or confirmed TB patient was NOT in a negative pressure and HEPA filtered room:
      i. Post the Airborne Precautions sign and keep the door closed.
      ii. Call Engineering for a HEPA filter. To enter the room staff must wear an appropriate respirator (i.e. N95 or PAPR). Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

M. **ROOM SHUT DOWN TIME:**

1. Keep the Airborne Precautions sign posted
2. Leave the HEPA filter running with door closed for specified time. Post a sign that specifies this time period.
   a. AIIR Negative Pressure Room

AIIR/Negative Pressure Rooms	Length of Time AIIR Negative Pressure Room is Closed
ED-C26, 143, 243, 443, 287, 387, 487, NICU	30 min
Bronchoscopy, 200, 201	1 hour
PCU 301, 312, 326	2 hours

   b. Non-Negative Pressure room

Location in Non-Negative Pressure Rooms	Length of Time Non-Negative Pressure Room is Closed
Surgery	30 min
1N/S, MCH, Pavillion, East/West Tower, Radiology/MRI/CT, ED	1 hour
PCU 3N/S	2 hours

3. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed.
4. After the time period has ended, discontinue Airborne Precautions.
5. If the patient is no longer infectious or TB has been ruled out: No special precautions needed. The door may be immediately opened and the room cleaned as usual.

N. **ANNUAL TUBERCULOSIS SCREENING:**

1. Auxiliary and Employees: See the Employee Health & Wellness Policy Manual: TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners. It is highly recommended that all active medical staff be fit-tested upon hire and annually.

O. **AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:**

1. A list of all job classifications in which employees have occupational exposure is available in the Employee Health & Wellness Policy Manual: Respiratory Protection Program (see Appendix C).

P. **ISOLATION PRECAUTIONS:**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant staff (IC.5.2).

Q. **HIGH HAZARD PROCEDURES:**

1. High hazard procedures include but not limited to
   a. Intubation and Extubation
   b. Sputum Induction
   c. Endotracheal & Tracheostomy Tube Care
   d. Bronchoscopy
   e. Pulmonary Function Tests

f. Aerosolized administration of pentamidine or other medication
g. Autopsy

2. For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator.
3. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR) except in an operating room or procedure room during an invasive procedure where there is a sterile field wear a N95 mask.
   a. Contact Materials for PAPRs supplies
4. Although Cal OSHA requires PAPRs for high hazard procedures on suspect/confirmed airborne disease patients, CDPH does allow the use of N95 Respirators instead of PAPRs if it interferes with the successful performance of the task or the procedure is performed with the patient in a ventilated enclosure.

R. **SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS:**

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."
2. Emergency Department
   a. Engineering Controls during a surge of patients with ATD is addressed in the TCHD Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*.
   b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
   c. Staff wears PAPRs or N95 Respirator during high hazard procedures (listed above) for disease spread by the airborne route.
   d. N95 respirators or PAPRs are used during patient contact for diseases spread by airborne route.
   e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
   f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for AIIR C-26.
   g. When room C-26 is not available a private room is used.
   h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
   i. Patients may be cohorted in designated rooms or bays when indicated.
   j. Patients suspected of having ATDs are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
   l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
   m. When used for a patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
   a. Patients who are admitted with airborne transmissible diseases are admitted to AIIRs on nursing units.
   b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions.
   c. Doors are kept closed.
   d. Patients in Droplet precautions do not need AIIRs for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both

Airborne and Droplet Precautions will be done in AIIR. See chart above for selection on type of respirator.

e. AIIRs shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with airborne transmissible disease has occupied the room. (See Room Shut Down Time)

4. Pulmonary Services
   a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
   b. N95 respirators or PAPRs are used during Bronchoscopy.
   c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The staff should wear an N95 or PAPR during this treatment (see High Hazard Procedures).
   e. Bronchoscopy suite will remain closed for the designated time when procedure is performed on a patient with known or suspected ATD.
   f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.
5. Women and Newborn Services (WNS)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by airborne route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery
      i. Operating Room Suites may have portable HEPA units installed for mothers who have suspected ATD.
      ii. Staff are to follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPRs for Airborne Precautions.
6. Laboratory Services
   a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
   b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy
7. Facilities Management Staff
   a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
   b. N95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.
8. Personal Protective Equipment
   a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
   b. Respiratory Protection including N95 respirators or PAPRs is required in any hospital location in the following circumstances:
      i. Entering an Airborne Precaution Room that is occupied or has been recently occupied (refer to Section M: Room Shutdown Time) by a patient with suspected or known Airborne transmitted ATD.
      ii. Attending high hazard procedure
   c. Respirator Shortages
      i. In the event of reported shortages of N95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):

1) TCHD will maintain a cache of N95 respirators in accordance with the disaster plan.
2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
3) According to available stock, N95 respirators will be prioritized for distribution to areas where high hazard procedures are performed.
4) Re-use of N95 respirators is acceptable for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
5) Reuse of N95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
   a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD.
   b) The respirator integrity remains intact
   c) During the care of intubated and ventilated patients (closed circuit suction systems).

ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N95) the following steps may be considered:
1) Prioritize available N95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPRs may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N95 respirators, surgical masks will be provided to the employee.

iii. Positive Air Purifying Respirators (PAPRs)
1) PAPRs used for bronchoscopy are maintained in Respiratory Care Department.
2) SPD stores and maintains all other PAPRs.
3) Units are cleaned; disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used.

9. Admissions and transfers of patients with known or suspected airborne transmissible ATD:
   a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
   b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
   c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
10. Influenza Season

a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty as directed by the facility. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.
c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

S. **MEDICAL SERVICES:**

1. Vaccinations are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATDs.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies.

T. **TRAINING:**

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
   a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

U. **REVIEW SCHEDULE:**

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected

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

1. Active/Rule Out Tuberculosis (TB) Surgery Protocol
2. Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)
3. Employee Health and Wellness Policy: Immunization
4. Employee Health and Wellness Policy: Respiratory Protection
5. Infection Control Policy: Risk Assessment and Surveillance Plan
6. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
7. Infection Control Policy: Healthcare Associated Infections, Defined
8. Infection Control Policy: Standard and Transmission-Based Precautions
9. Type and Duration of Precautions - Disease Specific
10. Infection Control Policy: Ebola Plan

W. **REFERENCE(S):**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 (last updated 02/15/2017)
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance https://www.cdc.gov/flu/professionals/index.htm, Accessed 2/14/19
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-ATD-RespSelectGuide.pdf
5. CDPH Ebola Virus Disease for Healthcare Professionals

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx

6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
7. CDPH: Cal-OSHA Aerosol Transmissible Diseases Standard, Title 8 CCR Section 5199 August 5, 2009 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx
8. CDC: Tuberculin Skin Testing for TB dated May 11, 2016. https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm
9. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.
10. Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. Dated May 2015. https://www.osha.gov/Publications/OSHA3767.pdf
11. CDPH/CTCA: California AdultTuberculosis Risk Assessment: September 2018 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf
12. CDPH Respirator Toolkit August 2015 (CDC, OSHA, NIOSH May 2015) page 16 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf
13. **Guidelines for the Assessment of Tuberculosis Patient Infectiousness and Placement into High and Lower Risk Settings (ctca.org)**
14. **TB-454eTBServicesBrochure.pdf (sandiegocounty.gov)**
~~12.~~15. **Tuberculosis Control and Refugee Health Program (sandiegocounty.gov)**

Tri-City Health Care District
Oceanside, California

AIRBORNE PRECAUTIONS

Surgery Protocol

ADMINISTRATIVE CONTROLS	ENVIRONMENTAL CONTROLS	RESPIRATORY PROTECTION
• Postpone non-urgent procedures on suspected/confirmed TB patients until known to be non-infectious. • If necessary to proceed, schedule procedure as last case of the day, at low traffic times, whenever possible. • Case may be performed in any OR, but it is preferred there be no ongoing cases in the adjacent OR's. WHEN THE CASE IS SCHEDULED NOTIFY: • Infection Control- (Fernanda Rivera x0203 and Rabecka Moore x5696) • POH (x5452) • PACU (x7264) • Engineering (x7148) of date/time of procedure to set up HEPA filters in OR and PACU • Anesthesia Charge to assure anesthesiologist has been fit tested and knows N95 size • Notify pathology lab if TB specimens will be sent to lab. *DAY BEFORE PROCEDURE, IF POSSIBLE:* Assign staff and assure fit testing is completed and individuals know their N95 mask size. DAY OF SURGERY: • Obtain 3 Airborne Precaution Signs • Obtain five PAPR Units or N95 • Prior to transporting the patient to the OR, send OR RN to the patient's unit to pre-op patient and complete handoff report.	PRE-OP: • Admit patient directly to the OR from the floor/unit. Do not stop in POH. OR: • Place portable HEPA unit in OR, positioned near the patient's head with ventilation outflow in the direction of the door. • Utilize the portable HEPA unit in the OR during intubation and extubation. Turn the unit OFF during the procedure. • Keep OR doors closed, minimize traffic in/out of room and in surrounding areas. • A "runner" should be positioned outside the OR to minimize door openings during the procedure. • Display Airborne Precautions signs on all doors to OR. • Close all doors after leaving the OR and keep room vacant with HEPA filter running for **ONE (1) HOUR** after patient leaves room, then perform normal room turnover. • Remove HEPA unit and return to proper location. POST-OP: • Place portable HEPA unit in PACU cubicle, with ventilation outflow in the direction of the door. • Post Airborne Precautions signs on cubicle door. • Place patient in cubicle post-op and keep cubicle door closed. • Close cubicle door after patient leaves and keep room vacant with HEPA filter running for **ONE (1) HOUR**, then perform normal room turnover. • Remove HEPA unit and return to proper location.	PATIENT: • Provide surgical mask for patient during transport. • Intubated patients: Anesthesiologist to place expiratory filter (from Anesthesia Workroom) on the ambu bag (at PEEP valve) during transport. HEALTH CARE PROVIDERS: • N95 Respirator or Powered Air Purifying Respirator (PAPR) required during intubation and extubation for the anesthesiologist and anyone assisting anesthesia at the head of the table. • *PAPR's are not to be used near the sterile field.* • Once the patient is intubated, all staff should wear N95 mask until the procedure is complete. • Fit testing for N95 mask must be completed each year. Healthcare providers who fail fit testing may not be scheduled in a sterile procedure with Airborne Precautions.

Tri-City Health Care District
Oceanside, California

AIRBORNE PRECAUTIONS
Surgery Protocol

LATENT VS. ACTIVE TUBERCULOSIS

LATENT TB Infection (LTBI)	ACTIVE TB Infection
Persons with latent TB infection are not infectious and cannot spread TB infection to others	Persons with active TB disease are considered infectious and may spread TB bacteria to others.
• Usually has a skin test or blood test result indicating TB infection • Has a normal chest x-ray and a negative sputum test (Acid Fast Bacilli (AFB) smears x3 OR Nucleic acid amplification test (NAAT) negative x2 OR AFB smear positive and NAAT negative x2) • Has TB bacteria in his/her body that are alive, but inactive • Does not feel sick • Cannot spread TB bacteria to others • Has had, undergoing or needs treatment for latent TB infection to prevent TB disease (≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated AND Clinical improvement.)	• Usually has a skin test or blood test result indicating TB infection • May have an abnormal chest x-ray, or positive sputum smear or culture (Acid Fast Bacilli (AFB) smears x3 OR Nucleic acid amplification test (NAAT) negative x2 OR AFB smear positive and NAAT negative x2) • Has active TB bacteria in his/her body • Usually feels sick and may have symptoms such as coughing, fever, and weight loss • May spread TB bacteria to others • Needs treatment to treat TB disease (≥14 daily doses of appropriate treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated AND Clinical improvement.)

TB treatment can take 4, 6, or 9 months or more depending on the regimen. Healthcare providers can choose the appropriate TB treatment regimen based on drug-susceptibility results, coexisting medical conditions and potential for drug-drug interactions. TB treatment regimens include:

- 4-month Rifapentine-moxifloxacin TB Treatment Regimen
  - high-dose daily rifapentine (RPT) with
  - Moxifloxacin (MOX),
  - Isoniazid (INH), and
  - Pyrazinamide (PZA)
- 6- or 9-month RIPE TB Treatment Regimen
  - Rifampin (RIF),
  - Isoniazid (INH),
  - Pyrazinamide (PZA), and
  - Ethambutol (EMB)

Sources:

CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

Fact Sheets | General | Latent TB Infection vs. TB Disease | TB | CDC. (n.d.). https://www.cdc.gov/tb/publications/factsheets/general/ltbiandactivetb.htm

Tuberculosis (TB) - treatment for TB disease. (2023, March 22). Centers for Disease Control and Prevention. https://www.cdc.gov/tb/topic/treatment/tbdisease.htm

Tri-City Health Care District
Oceanside, California

Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

CATEGORY	SETTING	CRITERIA
TB suspect - Not on treatment for suspect active TB	PCU	3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative
TB case or suspect on treatment for active TB -AFB smear positive -No risk factor for MDR-TB	PCU	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement
TB case or suspect on treatment for TB -AFB smear negative X3 -No risk factor for MDR-TB	PCU	At least 5 daily doses of treatment for TB taken and tolerated
TB case or suspect on treatment for TB -At increased risk for MDR-TB	PCU	1. Obtain direct genetic test, if available, for Rifampin resistance 2. If direct genetic test not available, while phenotypic DST for Rifampin is pending, other criteria for patients with known MDR-TB, or criteria for patients not at increased risk of MDR-TB, or criteria for patients not at increased risk of MRD-TB may be applied, at the discretion of the local TB controller
Known MDR-TB case	PCU	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement 4. At least 2 consecutive negative sputum cultures without a subsequent positive culture

Reference: CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

Tri-City Health Care District
Oceanside, California

Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)

Patient has signs and symptoms or chest x-ray compatible with TB

AND

Unstable housing or resident in a group setting

OR

Acutely ill or needing invasive diagnostic or therapeutic procedure

Admit to Medicine and place on

Airborne Precautions

For assistance

AND

Stable, non-group housing

AND

Not acutely ill or needing invasive diagnostic or therapeutic procedure

Discharge the patient with a written plan for outpatient care & surgical masks to wear
AND
Instruct the patient to remain on home isolation[1] until infectiousness is ruled out
AND
Alert the TB Control Program ASAP, but no longer than 24 hours.

[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCHD Infection Control: call ext. 5696

Tri-City Health Care District
Oceanside, California

Tuberculosis (TB) Risk Assessment Worksheet CY2024

Scoring √ or Y = Yes	X or N = No	NA = Not Applicable

1. Incidence of TB – CY2023 DATA

What is the incidence of TB in your community (county or region served by the health-care setting), and how does it compare with the state and national average? What is the incidence of TB in your facility and specific settings and how do those rates compare? (Incidence is the number of TB cases in your community the previous year. A rate of TB cases per 100,000 persons should be obtained for comparison.)* This information can be obtained from the state or local health department.	Community rate: **6.3** State rate: **4.7** National rate: **2.5** Facility rate: **9.3 (4/42,850 pt days * 100,000)**
Are patients with suspected or confirmed TB disease encountered in your setting (inpatient and outpatient)?	**Yes** No
If yes, how many patients with suspected and confirmed TB disease are treated in your health-care setting in 1 year (inpatient and outpatient)? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	
If no, does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** No
Currently, does your health-care setting have a cluster of persons with confirmed TB disease that might be a result of ongoing transmission of *Mycobacterium tuberculosis* within your setting (inpatient and outpatient)?	Yes **No**

	Suspect	Confirmed
1 yr ago (2023)	**23**	**4**
2 yrs ago (2022)	**11**	**3**
5 yrs ago (2019)	**20**	**12**

2. Risk Classification

Inpatient settings	
How many inpatient beds are in your inpatient setting?	**387 beds**
How many patients with TB disease are encountered in the inpatient setting in 1 year? Review laboratory data, infection-control records, and databases containing discharge diagnoses.	Previous year (2023): **8** 5 years ago (2019):**12**
Depending on the number of beds and TB patients encountered in 1 year, what is the risk classification for your inpatient setting? (See Appendix C.)	**o Low risk** o Medium risk o Potential ongoing transmission
Does your health-care setting have a plan for the triage of patients with suspected or confirmed TB disease?	**Yes** No

3. Screening of HCWs for *M. tuberculosis* Infection

Does the health-care setting have a TB screening program for HCWs?	**Yes** No
If yes, which HCWs are included in the TB screening program? (Check all that apply.) **√o Physicians** **√o Mid-level practitioners (nurse practitioners [NP] and physician's assistants [PA])** **√o Nurses** **√o Administrators** **√o Laboratory workers** **√o Respiratory therapists** **√o Physical therapists** **√o Contract staff**	**√o Janitorial staff** **√o Maintenance or engineering staff** **√o Transportation staff** **√o Dietary staff** **√o Receptionists** **√o Trainees and students** √o Construction or renovation workers **√o Volunteers** o Others_____

Is baseline skin testing performed with two-step TST for HCWs?	**Yes** No
Is baseline testing performed with QFT or other BAMT for HCWs?	**Yes** No
How frequently are HCWs tested for *M. tuberculosis* infection?	**Every other year & Upon new hire**
Are the *M. tuberculosis* infection test records maintained for HCWs?	**Yes** No
Where are the *M. tuberculosis* infection test records for HCWs maintained? Who maintains the records?	**Test records are maintained by Employee Health**
If the setting has a serial TB screening program for HCWs to test for *M. tuberculosis* infection, what are the conversion rates for the previous years? † 1 year ago (2023) **2** 2 years ago (2022) **1** 3 years ago (2021)**1** 4 years ago (2020)**1** 5 years ago (2019)**0**	
Has the test conversion rate for *M. tuberculosis* infection been increasing or decreasing, or has it remained the same over the previous 5 years? (check one)	Increasing Decreasing No change

4. TB Infection-Control Program

Does the health-care setting have a written TB infection-control plan?	**Yes** No
Who is responsible for the infection-control program?	**Tri-City Medical Center Infection Prevention**
When was the TB infection-control plan last reviewed or updated?	**02/2023**
Does the written infection-control plan need to be updated based on the timing of the previous update (i.e., >1 year, changing TB epidemiology of the community or setting, the occurrence of a TB outbreak, change in state or local TB policy, or other factors related to a change in risk for transmission of *M. tuberculosis*)?	**Yes** No
Does the health-care setting have an infection-control committee (or another committee with infection control responsibilities)?	**Yes** No

If yes, which groups are represented on the infection-control committee? (Check all that apply.)

o **Physicians**	o **Laboratory personnel**
o **Health and safety staff**	o **Nurses**
o Administrator	o **Epidemiologists**
o **Engineers**	o Risk assessment
o **Pharmacists**	o Others (specify)_____
o Quality control (QC)	

5. Implementation of TB Infection-Control Plan Based on Review by Infection-Control Committee

Has a person been designated to be responsible for implementing an infection-control plan in your health-care setting? If yes, list the name(s): **Rabecka Moore, Fernanda Martinez**	**Yes** No

Based on a review of the medical records, what is the average number of days for the following:

- Presentation of patient until collection of specimen 0-1 day
- Specimen collection until receipt by laboratory 1 day
- Receipt of specimen by laboratory until smear results are provided to health-care provider 1 day
- Diagnosis until initiation of standard anti-tuberculosis treatment 0 days
- Receipt of specimen by laboratory until culture results are provided to health-care provider 1 day
- Receipt of specimen by laboratory until drug-susceptibility results are provided to health-care provider 1day

Receipt of drug-susceptibility results until adjustment of anti-tuberculosis treatment, if indicated 1 day

- Admission of patient to hospital until placement in airborne infection isolation (AII) 1 day

Through what means (e.g., review of TST or BAMT conversion rates, patient medical records, and time analysis) are lapses in infection control recognized?	Conversion rates, employee exposures
What mechanisms are in place to correct lapses in infection control?	Exposure control plan
Based on measurement in routine QC exercises, is the infection-control plan being properly implemented?	Yes No
Is ongoing training and education regarding TB infection-control practices provided for HCWs?	Yes No

6. Laboratory Processing of TB-Related Specimens, Tests, and Results Based on Laboratory Review

Which of the following tests are either conducted in-house at your health-care setting's laboratory or sent out to a reference laboratory?	In-house	Sent out
Acid-fast bacilli (AFB) smears		x
Culture using liquid media (e.g., Bactec and MB-BacT)		x
Culture using solid media		x
Drug-susceptibility testing		x
Nucleic acid amplification (NAA) testing		x

What is the usual transport time for specimens to reach the laboratory for the following tests?	
AFB smears	24-48 hours
Culture using liquid media (e.g., Bactec, MB-BacT)	24-48 hours
Culture using solid media	24-48 hours
Drug-susceptibility testing	24-48 hours
Other (specify)	24-48 hours
NAA testing	24-48 hours

Does the laboratory at your health-care setting or the reference laboratory used by your health-care setting report AFB smear results for all patients within 24 hours of receipt of specimen? What is the procedure for weekends?	Yes No Same procedure, 7 days a week

7. Environmental Controls

Which environmental controls are in place in your health-care setting? (Check all that apply and describe)

Environmental control	Description
o AII rooms	13 rooms
o Local exhaust ventilation (enclosing devices and exterior devices)	
o General ventilation (e.g., single-pass system, recirculation system.)	
✓ Air-cleaning methods (e.g., high-efficiency particulate air [HEPA])	

What are the actual air changes per hour (ACH) and are design requirements met for various rooms in the setting?

ROOM	ACH	DESIGN Requirement met
ED-C26	18	Yes
143	21	Yes
200	17	Yes
201	13	Yes
243	19	Yes
287	17	Yes
301	29	Yes
312	17	Yes
326	19	Yes
387	17	Yes
443	23	Yes
487	13	Yes
NICU	16	Yes

Which of the following local exterior or enclosing devices such as exhaust ventilation devices are used in your health-care setting? (Check all that apply)

✓ Laboratory hoods
o Booths for sputum induction
✓ Tents or hoods for enclosing patient or procedure

What general ventilation systems are used in your health-care setting? (Check all that apply)

✓ Single-pass system -South Tower
o Variable air volume (VAV)
✓ Constant air volume (CAV) - All
✓ Recirculation system - pavillon and center towers
o Other_____

What air-cleaning methods are used in your health-care setting? (Check all that apply)

HEPA filtration
- ✓ Fixed room-air recirculation systems – AIIR and surgery
- ✓ Portable room-air recirculation systems

UVGI
- o Duct irradiation
- o Upper-air irradiation

How many AII rooms are in the health-care setting? 13

What ventilation methods are used for AII rooms? (Check all that apply)
Primary (general ventilation):
✓ Single-pass heating, ventilating, and air conditioning (HVAC)
o Recirculating HVAC systems

Secondary (methods to increase equivalent ACH):
o Fixed room recirculating units
✓ HEPA filtration

o Other (specify) _____

Does your health-care setting employ, have access to, or collaborate with an environmental engineer (e.g., professional engineer) or other professional with appropriate expertise (e.g., certified industrial hygienist) for consultation on design specifications, installation, maintenance, and evaluation of environmental controls?	**Yes** No Annual certification
Are environmental controls regularly checked and maintained with results recorded in maintenance logs?	**Yes** No
Are AII rooms checked daily for negative pressure when in use?	**Yes** No
Is the directional airflow in AII rooms checked daily when in use with smoke tubes or visual checks?	**Yes** No
Are these results readily available? Kept in control plant	Yes **No**
What procedures are in place if the AII room pressure is not negative?	___No procedure. Facility engineers to assess first, then Outside certification company notified
Do AII rooms meet the recommended pressure differential of 0.01-inch water column negative to surrounding structures?	**Yes** No

8. Respiratory-Protection Program

Does your health-care setting have a written respiratory-protection program?	**Yes** No
Which HCWs are included in the respiratory protection program? (Check all that apply) ✓ Physicians ✓ Mid-level practitioners (NPs and PAs) ✓ Nurses ✓ Administrators ✓ Laboratory personnel ✓ Contract staff ✓ Construction or renovation staff ✓ Service personnel	✓ Janitorial staff ✓ Maintenance or engineering staff ✓ Transportation staff ✓ Dietary staff Students o Others (specify)_____

Are respirators used in this setting for HCWs working with TB patients? If yes, include manufacturer, model, and specific application (e.g., ABC model 1234 for bronchoscopy and DEF model 5678 for routine contact with infectious TB patients).

Manufacturer	Model	Specific application
3M	1870+	Routine contact, procedures

Is annual respiratory-protection training for HCWs performed by a person with advanced training in respiratory protection?	**Yes** No
Does your health-care setting provide initial fit testing for HCWs? If yes, when is it conducted? ____upon hire_____	**Yes** No
Does your health-care setting provide periodic fit testing for HCWs? If yes, when and how frequently is it conducted? ____annual_____	**Yes** No
What method of fit testing is used? Describe.	
Is qualitative fit testing used?	**Yes** No

Tuberculosis (TB) Risk Assessment Worksheet CY2024

Is quantitative fit testing used?	Yes **No**

9. Reassessment of TB risk

How frequently is the TB risk assessment conducted or updated in the health-care setting?	**Annually**
When was the last TB risk assessment conducted?	**2023**

What problems were identified during the previous TB risk assessment?

1) **No problems identified. TCMC risk classification is low**
2) _____
3) _____

What actions were taken to address the problems identified during the previous TB risk assessment?

1) _____
2) _____

Did the risk classification need to be revised as a result of the last TB risk assessment?	Yes **No**

* If the population served by the health-care facility is not representative of the community in which the facility is located, an alternate comparison population might be appropriate.

† Test conversion rate is calculated by dividing the number of conversions among HCWs by the number of HCWs who were tested and had prior negative results during a certain period (see Supplement, Surveillance and Detection of *M. tuberculosis* infections in Health-Care Settings).

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

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

REVISION DATE: 04/01, 06/03, 04/07, 10/07, 10/13, 08/16, 12/19, ~~03/24~~05/23

Infection Control Department Approval:	~~12/22~~03/24
Infection Control Committee Approval:	~~04/23~~03/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/23~~04/24
Administration Approval:	~~05/23~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/23

A. **INTRODUCTION:**

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

B. **PURPOSE:**

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

C. **PROCEDURE:**

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

D. **ENGINEERING:**

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

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

followed during the construction.

c. Direct traffic away from the construction site.
d. Notify the Infection Preventionist and the Safety Officer if mold is encountered during a construction/renovation project and implement precautions in Infection Control Policy: Mold Abatement IC 13.3.
e. To isolate renovation areas from occupied areas, use airtight barriers. Ensure that barriers are fire retardant and sealed tightly.
f. Construction or renovation projects that fall into the **Category III, IV, or V** category will have containment performed by qualified personnel. See Infection Control Construction Permit (ICRA) Form).
g. Adequate window seals should be installed and maintained to prevent outside air from entering the room.
h. Reusable barrier cubes are cleaned after each use. Take outside and hose off both the inside and outside of the container. Spray and wipe with hospital-approved disinfectant and allow the plastic to air dry.
i. After completion of construction, contractor will perform construction clean-up.
j. Engineering will notify Environmental Services to perform a terminal clean and disinfection of the involved area prior to placing back into service.

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

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

E. **FORM(S):**

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

F. **REFERENCE(S):**

1. Bartley, J.M., APIC State of the Art Report: The role of infection control during construction in healthcare facilities. Am J Infect Control 2000; 8 156-69.
2. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2008. On-line at APIC.com **(Reviewed 03/08/24)**
3. Infection Prevention Manual for Construction & Renovation: **2019 Addendum. Arlington, VA: Association for Professionals in Infection Control & Epidemiology; 2019. (Reviewed 03/08/24)**~~APIC 2015~~
4. Cotten, B., (2014) APIC Text of Infection Control & Epidemiology (4th ed): Construction & Renovation Chapter 116 **(Online APIC text Reviewed 03/08/24)**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY

ISSUE DATE: 02/01	**SUBJECT:** Standards for Endovascular Repair of Aortic Aneurysms
REVISION DATE~~(S)~~: 09/07, 04/17, 05/20	**POLICY NUMBER:** 8710 – 503

Department Approval:	~~02/20~~05/23
Division of GVS Approval:	~~03/20~~04/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~04/24
Administration Approval:	~~05/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **STANDARDS:**

1. All cases involving endovascular repair of aortic aneurysms must meet the following minimum criteria for adequate facilities and physician skills.
   a. The minimum criterion for the facility is:
      i. Digital subtraction angiography with roadmap capabilities.
      ii. A large Field of View image intensifier (15 or 16 inches) * with a 1024 matrix.
      iii. Power injector for contrast administration.
      iv. Appropriate supply of balloons, guidewires, stents, coils and other embolic materials.
      v. Appropriate level of sterility.
      vi. Adequate space and facilities for anesthesia
      vii. Interventional Physician and Surgical Registered Nurses.
      viii. Interventional technologist.

      *When combined intraoperative access and endoluminal graft is performed in the operating room, a smaller image intensifier may be acceptable when agreed upon by the involved physicians.
   b. The criterion for physician skills is:
      i. Interventional Physician must have current independent (has been released from proctoring) Tri-City Healthcare District (TCHD) privileges for catheter-based peripheral vascular interventional procedures.
      ii. Interventional Physician must have met the minimum criteria for device- specific training/certification as defined by the manufactures of the device.
      iii. Vascular Surgeons must have current independent (has been released from proctoring) TCHD privileges for open repair of abdominal and/or thoracic aortic aneurysm repair.
2. During all cases, at least one physician credentialed in Interventional Radiology and one physician credentialed in Vascular Surgery must be present.
3. Proctoring Criteria:
   a. Five cases performed during the first six months after granting of the privilege will be proctored. The proctor must be privileged for the procedure that he/she is proctoring.
4. Reappointment Criteria:
   a. Maintenance of Endovascular Repair of Aortic Aneurysm requires ongoing experience in performing these procedures with acceptable success and complication rates.
   b. In order to qualify for reappointment, the minimum number of cases (5) to be performed in a two-year period.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 03/07

SUBJECT: Surgical Assistance

REVISION DATE: 11/11, 07/12, 04/17, 03/19, 02/22

POLICY NUMBER: 8710 – 545

Medical Staff Department Approval:	**~~01/21~~03/24**
Operating Room Committee Approval:	**~~04/21~~04/24**
Division of GVS Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/22~~04/24**
Administration Approval:	**~~02/22~~05/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/22**

A. **PURPOSE:**
1. To identify Amount and Level of Assistance required in Surgical Cases.

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
GENERAL / VASCULAR					
Abdominal Perineal/ Low Anterior Resection	X			X	
Robotic Procedures (Major, as determined by the surgeon)	X			X	
Whipple/Major Liver Resection	X			X	
Open aortic procedures	**X**		**X**		
THORACIC					
Robotic Thoracic Procedures (Major, as determined by the surgeon)	~~X~~			X	
UROLOGIC					
Open Prostatectomy Procedures	X			X	
Open Renal Procedures	X			X	
Cystectomies	X		X		
OB/GYN					
Hysterectomy Procedures	X			X	

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
Cesarean Sections	X			X CNM	X Emergency
CV					
Open Heart Procedures	X	X	X	X*	

2. Amount and level of assistance for all other procedures are at the discretion of the operating surgeon.
3. For emergent surgical cases, the amount and level of assistance for procedure may be waived at the discretion of the surgeon.
4. Cystectomy procedures:
   a. Requires two (2) physicians; can be two urologists or one urologist and one general surgeon
5. Open heart procedures:
   a. 1st Assistant must be another cardiac/thoracic surgeon or surgeon
   b. 2nd Assistant may be MD or PA/RNFA

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Pastoral Care**

ISSUE DATE: **08/96**
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/033, 01/05, 06/07, 06/10, 04/13, 07/17, 10/21

Department Approval:	**~~08/20~~05/24**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/21~~05/24**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/21**

A. **PURPOSE:**
1. To define availability of pastoral care, religious, and spiritual consultation to patients.

B. **POLICY:**
1. Recognizing that spiritual values and issues may affect patient response to treatment, patients will ~~have access to a list of local clergy who have agreed to provide consultation on an as needed basis.~~**be provided options for local clergy when requested. Options will reflect the patient's stated spiritual orientation, preferences they share, and/or requests they make.**

C. **PROCEDURE:**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) clinical and administrative staff.
2. All patients' spiritual needs are assessed in the Biopsychosocial assessment.
3. When a patient requests pastoral assistance or consultation, the OPBHS staff will provide that patient with a ~~multi-denominational~~ list of local clergy **according to their expressed preferences** or the name of Tri-City Healthcare District's (TCHD) chaplain who may be available for them.
4. If assistance in contacting community clergy is necessary the OPBHS staff will provide the patient with a telephone or assist in making the necessary arrangements.
5. If clergy is requested to come to the OPBHS, private office space will be provided for consultation.
6. Staff will maintain a supportive but unbiased relationship with patients regarding religious issues and patient's personal secular needs may be referred to community supports.

Tri-City Medical Center	Progressive Care Unit
PROCEDURE:	**RELEASE OF A DECEASED JUSTICE INVOLVED PATIENT**
Purpose:	To care for and release remains of deceased Justice Involved patients.

A. **PROCEDURE:**

1. The Registered Nurse (RN) will notify the ~~Sergeant~~ **Correctional Officer/Sergeant/Deputy,** and Progressive Care Unit (PCU) ~~Assistant Nurse Manager~~**Clinical Nurse Manager (CNM)** ~~(ANM)~~/Designee **or Administrative Supervisor** to report the death.
2. All justice involved patient deaths are reportable to the correctional facility and County Medical Examiner (ME).
   a. The primary RN or designee RN will:
      i. Notify the correctional facility and ME.
      ii. Provide the ME or ME representative with information as requested.
      iii. Document the ME~~r~~ or ME representative's name in the medical record.
      iv. Notify Lifesharing.
3. Nursing must adhere to the following procedure:
   a. The decedent's room is considered a crime scene.
   b. Patient is to remain attached (connected) to all equipment and devices such as the following (this is not an inclusive list). The equipment may be turned off.
      i. Ventilators
      ii. Infusion pumps
      iii. Cardiac monitor or Telemetry transmitter (tele box) – silence alarms
      iv. Sequential stocking pump
      v. Air mattresses should remain inflated to maintain decedents skin
   c. Turn off the following and leave patient attached (connected)
      i. Oxygen flow meter
         1) Turn off the flowmeter and do not disconnect the patient from the oxygen tubing
      ii. Oxygen delivery devices e.g., nasal cannula, simple mask, non-rebreather etc.
      iii. Turn off intravenous (IV) infusion(s) do not remove the IV catheter(s)
      iv. Urinary drains; e.g. Foley, ~~PureWick~~**external cathers**, condom catheters or IV solutions
      v. Rectal tubes and rains
      vi. Chest drains
      vii. Dressings
      viii. Drains, etc., Jackson Pratt (JP)
      ix. Electrodes
      x. Sequential stockings
   d. Gather all nursing equipment such as stethoscopes before leaving room.
   e. Once you leave patients room it will be sealed and you will not be allowed to return until the ME or ME representative arrives.
   f. Justice involved (JI) patients remain shackled until correctional officer or ME releases the decedent .
4. Correctional Officer/Sergeant/Deputy will provide the Death Record Packet that includes:
   a. Necessary paperwork
   b. Finger printing materials
   c. Camera for pictures
   d. Initial Inmate Death Report:

Department Review	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
~~NEW~~ 12/17, 04/24	n/a	n/a	02/18, 04/24	05/24	03/18, n/a	03/18

i. The Initial Inmate Death Report must be filled out by the attending physician (unless attending designates the specialist – this is not preferred) within 24 hours of death.
   1) Nursing may not initiate or complete this form.
ii. The PCU ~~Manager, ANM designee~~ **Clinical Nurse Manager or the Charge Nurse designee** will fax the completed Initial Inmate Death Report to the Chief Medical Officer at the JI decedent's -institution within 24 hours of death.
iii. This document is not part of the TCHD medical record. If the death occurs on a unit other than the PCU, nursing must bring the completed Initial Inmate Death Report to the PCU ~~Manager or ANM~~/**Clinical Nurse Manager or Charge Nurse** designee. The primary care nurse is responsible for completing all charting in Cerner.

5. On arrival of the ME or ME representative, the primary care RN will:
   a. Enter patients room with ME or ME representative to ensure that all infusions and hospital equipment is in place.
   b. Ask permission from ME or ME representative to remove infusions such as narcotics in Patient Control Analgesia.
   c. Remove all narcotics and waste per Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine.
   d. Narcotics are not allowed to be kept with the patient or transported outside of TCHD.
6. The ME or ME representative will complete the ME portion of the Initial Inmate Death Report once his/her investigation has been completed.
   a. The ME or ME representative may:
      i. Review the medical record
      ii. Ask staff assigned to the decedent questions regarding care, diagnosis, excreta, etc.
      iii. Clear the decedent's body for removal.
   b. The primary RN will ensure completion of the Authority for Release of Deceased Record.
   c. The ME or ME representative removing/transporting the decedent's body will fill out the bottom of the Authority for Release of Deceased Record.

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

1. Patient Care Service Procedure: Wasting Narcotics, Documentation in the Pyxis Machine
2. Patient Care Services Policy: Medical Examiner Notification
3. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes
4. Patient Care Services Policy: Patient Valuables Liability and Control
5. Patient Care Services Policy: Release of Deceased
6. Patient Care Services Procedure: Deceased Patient Care and Disposition
7. Security Department Policy: Morgue Release 224

Tri-City Medical Center
Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE: 03/18

SUBJECT: Safety Awareness for Justice Involved Patients

REVISION DATE~~(S)~~: 04/18

~~Department~~Progressive Care Unit Approval:	~~12/1710/2004/24~~
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/18~~04/24
Administration Approval:	05/24
Professional Affairs Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

A. **PURPOSE:**
1. To identify the state of California (CA) law enforcement agencies and Tri-City Healthcare District's (TCHD) rules for the well-being of hospital employees when providing care for outpatient and inpatient justice involved (JI) patients.

B. **DEFINITION(S):**
1. JI /Custody Patients – patients held involuntarily through operation of law enforcement authorities.
2. Correctional Officer (CO) – an employee of the CA Department of Corrections and Rehabilitation (CDCR).
3. Deputy- an employee of the San Diego (SD) County Sheriff Department Detention Facilities.
4. Law Enforcement Personnel – any sworn Officer recognized by the County, State or Federal Government that authority to detain a citizen.
5. Law Enforcement Restraint Devices – restraint devices used by law enforcement officials for custody, detention, and public safety reasons (per the Department of Health and Human Services).

C. **POLICY:**
1. JI patients have the same rights as all patients with certain safety considerations. These safety considerations are identified by regulatory agencies, TCHD, the CDCR, the SD Sheriff Department and all Law Enforcement agencies.
2. JI patients will be escorted throughout the hospital with two (2) Law Enforcement officers at all times.
3. Hospital staff must:
   a. Display a professional attitude and demeanor at all times.
   b. Follow the instructions and advice of the Officers related to safety issues at all times and ask if you are not sure of a circumstance.
      i. The Law Enforcement Officers are responsible to ensure the safety of the public, and the JI patient.
   c. Avoid placing yourself or an Officer in danger by not adhering to this policy.
   d. Follow the instructions and advice of the Officer related to safety at all times. Ask questions if uncertain.
4. Safety Behaviors:
   a. Be aware of your surroundings at all times.
   b. Do not leave anything within hands/arms reach of the patient.
   c. Be mindful of seemingly innocuous objects such as cardboard, paper, plastic, pens, toothbrushes, paperclips (these items may be used as weapons).

i. Items such as tissue boxes (remove the tissue from the box); do not leave the box with the patient.

d. Do not walk too close or in between patient who is out of their room and a Law Enforcement Officer.

e. Cell phones and other personal electronic devices are not allowed out on the Progressive Care Unit (PCU). They are to be left at home or in a locker. Staff will be required to lock up any device that is found on their person while working on the PCU.

f. No one is allowed to photograph a JI patient or an officer at any time.

g. Staff assigned or floating to the PCU will adhere to TCHD's dress code and the following:

i. No item shall be worn around the neck this includes a necklace, ID tag holder or stethoscope.

ii. Law Enforcement has asked that TCHD PCU staff do not wear solid orange or solid navy blue scrubs as these resemble clothing worn by JI individuals.

iii. No provocative dress this includes but is not limited to:

1) Low cut tops and/or cleavage revealing shirts, scrub tops, blouses, etc.

2) Sheer, see through, revealing, tight, and/or short skirts, dresses, pants and/or scrubs.

iv. Long hair shall be tied or pulled back using hair clips at all times when assigned to patient care. Braids may not hang down and must be no longer than shoulder line.

D. ENTERING AND LEAVING PATIENT ROOMS:

1. Designated Officer must enter occupied room ahead of staff. Officer will remain in room at all times while staff is providing patient care.
   a. Address the JI patient by their last name.
   b. Never refer to a JI patient using endearing words such as honey, dear, or sweetie or by their first name.
2. Before entering patient room, consider the items you may have that may be considered potentially dangerous.
3. Do not take items into a JI patient's room that are not required to provide care of that particular patient.
   a. Items that you do not need immediately shall be placed outside of the patient's room on a table.
4. Never leave needles, syringes, scissors, thermometers, razors, pens, combs, wrappers from supplies, dressing supplies or paperclips in a patient's rooms. Use caution when hanging glass intravenous (IV) vials. If accidentally dropped ensure that all pieces have been collected. Contact environmental services to clean and sweep floor.
5. Remove and discard all items including IV tubing, IV bags, bandages, oxygen (O_2) tubing, etc. in a trash receptacle outside of patient's room.
6. Always scan the room, floor, bed, patient, and bedside table before leaving the room.
7. Do not place anything in the trash receptacle in the patient's room. Discard all trash outside of the patient's room.

E. MEDICATION ADMINISTRATION:

1. Medications may only be administered by licensed staff. See Patient Care Services: Medication Administration. Approved nursing students:
   a. May administer oral medications only under the direct supervision of a TCHD registered nurse (RN).
   b. May not start IV lines.
   c. May not perform invasive procedures.
2. Officers may not administer or handle medications of any kind.
3. Do not leave medications unattended in patient's room.
4. Ensure you observe the patient swallowing the medications before leaving the room.

a. You may ask the patient to open their mouths to ensure the medications are swallowed and not pocketed under their tongue or buccal.
b. If medications are not properly swallowed (i.e. found in the buccal or under the tongue or you cannot validate the patient swallowed the medication), notify an Officer immediately.

5. Intermittent IV medications; i.e. IV piggybacks (IVPB):
   a. When IVPBs are complete, remove the medication tubing from the room, and discard in the appropriate trash receptacle outside of the patient's room.

F. **MEAL TRAYS:**

1. Do not serve JI patients food items between regular scheduled meal times.
   a. Exceptions: crackers may be given if a medication is to be administered with food or if ordered by physician for obstetrics (OB) patients.
   b. Upon order by the physician, patients may receive snacks or other food item. Inform the Officer that an order has been written.
2. Breakfast, lunch, and dinner will be the only food served.
   a. Exceptions will be made with a physician's order.
3. Sodas, ice cream, milk, juices, or other snacks will not be served without a physician's order.
   a. Patients are not allowed to have snacks between meals or make request for meals.
      i. Exceptions: OB patients, vegetarian or vegan.
4. Meal trays may be distributed by staff to patients after they are inspected by an Officer.
   a. Eating utensils must be checked and approved by an Officer.
      i. Straws, metal silverware, and alcohol-based hand wipes are not allowed in patient rooms.
   b. Meal trays are left in patients' room per the Officers instructions.
5. Meal trays may be removed from patient rooms after the tray is inspected.
   a. Patients are expected to eat their meals within 30 minutes.
6. Nothing by mouth (NPO) patient trays may be held in the kitchen. Trays may not be left in the medication room, nursing station, or in patient rooms.
7. Special Considerations:
   a. Patients admitted for swallowing foreign objects may not have small items such as juice boxes, straws, paper wrappers, or condiments left on their trays.
8. Hunger Strikes:
   a. Hunger Strike: California Department of Corrections and Rehabilitation Policy and the Division of Correctional Health Care Services, Chapter 22 or SD County Sheriff Department, depending on incarceration status, have policies that address hunger strikes. The TCHD primary care RN will follow the Progressive Care Unit Policy: Hunger Strike: Justice Involved Patients regarding hunger strikes.

G. **COMMUNICATION WITH JI PATIENTS:**

1. All communication concerns shall be communicated to the PCU Manager or designee immediately.
2. Do not discuss personal affairs.
   a. Patients do not have a reason to know any of your personal information.
   b. Keep your relationship with patients professional.
3. Do not trade, sell, barter, lend or otherwise engage in any other personal transactions with custody patients.
4. Do not directly or indirectly give or receive from patients or member of the patient's family anything in the nature of a tip, gift, or promise of a gift as this may be considered a violation of the law and you may be prosecuted.
5. Be mindful of the fact that they can hear your conversations with other staff in and outside of their room.
6. If touching a patient is not necessary, stay at arm's length when speaking to them.
7. Never argue with patient. Inform the Officer of any conflict. It is the Officer's responsibility to manage conflicts.
   a. If a patient becomes argumentative, leave the room.

b. If a patient asks for extra pain medications educate patient they you can only give what is ordered by the physician.

H. **INAPPROPRIATE BEHAVIORS BY CUSTODY PATIENTS:**

1. If a patient becomes uncooperative with medical treatment or exhibits inappropriate behavior, leave the room and ensure the appropriate Law Enforcement Officer is informed.
2. Do not accept compliments or inappropriate gestures from patients.
3. Report incidents to the appropriate Law Enforcement Officer immediately.

I. **RESTRAINT OR SECLUSION:**

1. Only TCHD employees may implement, apply, and monitor JI patients requiring restraint for non-violent/non self-destructive behavior.
2. Patients requiring Non-Violent Restraint:
   a. RNs providing care for patients requiring non-violent restraint shall follow Patient Care Services Policy: Restraints, Used for Non-Violent Non-Self-Destructive Behavior.
3. Patients requiring presenting with behaviors that are violent:
   a. RNs providing care for custody patients with violent behaviors shall inform the appropriate Officer immediately.
   b. If restraint is required, implement the Patient Care Services Policy: Restraint-Seclusion for Violent/Self-Destructive Behavior.
4. Law Enforcement Officers may restrain custody patients using Law Enforcement Restraint Devices. TCHD employees may not assist Law Enforcement Officers with the application or removal of the following law enforcement restraint devices:
   a. Handcuffs
   b. Manacles
   c. Shackles
   d. Chain-type restraint devices
   e. Restrictive devices used by law enforcement officials

J. **INCOMING CALLS:**

1. Calls received regarding a patients shall be directed to a Law Enforcement Officer.
2. When asked questions by telephone regarding a patient, the standard answer is "I have no information on this patient".
3. Inform a Law Enforcement Officer and PCU Manager of any unusual telephone calls.

K. **VISITORS:**

1. JI patients will not generally have visitors unless prior arrangements and special circumstances dictate; TCHD must be notified of special circumstances.
2. Visitors must be approved through the institutional visitor's process and must comply with the PCU visitation practices which include removal of all personal items, this includes but is not limited to the following:
   a. Coats
   b. Jackets
   c. Purses
   d. Backpacks
3. All staff and visitors must check in with an Officer.
4. Only visitors allowed per the appropriate Law Enforcement agency are allowed on the unit.
5. Visitors allowed on the unit will be identified and escorted on the unit as appropriate.

L. **DIALYSIS PATIENTS:**

1. The primary RN assigned to the patient will inform the dialysis RN of the following:
   a. Do not enter the room without an Officer.
   b. Only items or equipment that will be used to provide dialysis may be brought in the patient's room.

c. Every item brought in the patient's room must be removed immediately after use and at the completion of the dialysis treatment.
d. Do not leave bleach or any solutions in the patient's room unless the dialysis machine is being cleaned.

M. **DISCHARGE:**
1. Patients are not to be informed of their discharge date, time or plans.

N. **RELATED DOCUMENT(S):**
1. Administrative Policy: 415 Dress and Appearance Philosophy
2. Patient Care Services Policy: Justice Involved Patients
3. Patient Care Services Policy: Medication Administration
4. Patient Care Services Policy: Plan for Nursing Care
5. Patient Care Services Policy: Restraints, Used for Non-Violent Non-Self-Destructive Behavior
6. Patient Care Services Policy: Restraint-Seclusion for Violent/Self-Destructive Behavior
7. Progressive Care Unit Policy: Hunger Strike: Justice Involved Patient

O. **REFERENCE(S):**
1. Department of Health and Human Services. *Federal registry part IV. Centers for Medicare and Medicaid Services (CMS) 42CFR part 482.*
2. Joint Commission (2015). *Hospital accreditation standards.* Retrieved from http://www.jointcommission.org

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/20 **SUBJECT: After Hours Tissue Receiving**

REVISION DATE(S): 06/20

Department Approval:	~~03/20~~08/23
Operating Room Committee Approval:	~~03/20~~02/24
Department of Anesthesiology Approval:	n/a
Department of Pathology Approval:	~~04/20~~03/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~04/24
Administration Approval:	~~06/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **POLICY:**
1. Every attempt is made to receive tissue during normal business hours, however, in the event of an urgent/emergent need for tissue after hours, the following procedure shall be followed.
2. Only room temperature tissue will be accepted at the OR desk. All other (i.e., frozen) must be delivered to the Laboratory Tissue Bank.

B. **PROCEDURE:**
1. After hours ordering and delivery of room temperature tissue, grafts, valves and mesh:
   a. The surgeon shall alert OR staff of the need for a specific implant.
   b. Guidelines for OR staff ordering implants:
      i. The vendor will be verified as an approved tissue provider on the TIM application.
      ii. OR staff will document requested implant on OR Scheduling sheet, including requested implant name(s), size(s), and quantity.
      iii. OR staff will contact the company representative and provide the following information:
         1) Implant requested
         2) Surgery date and time
         3) Verification if requested implant contains human tissue
         4) If human tissue:
            a) Alert representative of need to use licensed courier to deliver tissue
            b) Alert representative to inform courier to provide copy of license to transport human tissue
   c. OR Staff responsibilities for receiving tissue:
      i. Verify tissue being delivered with the OR Scheduling Sheet.
      ii. Verify courier license is present and current if human tissue. Make a photocopy of the courier license and retain with tissue documents.
      iii. Verify packaging is not damaged.
      iv. Verify temperature is within range, if required.
      v. Stamp manufacturer packing slip with stamp provided.
      vi. Document condition of product being received.
      vii. Place packing slip with completed documentation in materials box at the OR desk.

I inspected the products listed above on receipt and determined for each that the product appearance was acceptable, the container was intact and the label was complete, affixed, and legible

Print Name

Signature Date

Is temp indicator within range? [ ]Yes [ ]No [ ]n/a
Ambient Room Temp (no indicator) [ ]Yes [ ]No

Courier Lic # _____

2. After hours delivery of room temperature tissue, grafts, valves, and mesh (i.e., tissue order has been placed by Materials Management):
   a. Scheduled after-hours delivery:
      i. Materials Management:
         1) A representative from Materials Management will verbally alert the OR Supervisor/designee of the scheduled date and time of delivery.
         2) Materials representative will provide the OR Supervisor/designee a copy of the printed Purchase Order (PO), including the following information:
            a) Manufacturer
            b) Manufacturer representative name and contact information
            c) Name and catalog number of product being delivered
            d) Amount of product being delivered
            e) Type of tissue: i.e., human tissue, bovine, porcine, synthetic
            f) Expected date and time of delivery
         3) If human tissue is being delivered, materials representative will alert courier service of need to provide a copy of human tissue courier service license upon delivery to the OR.
         4) Human tissue can only be transported via a licensed courier.
      ii. OR staff responsibilities for receiving tissue:
         1) Verification of tissue being delivered with PO issued by materials.
         2) Verification courier license is present and current if human tissue. Make a photocopy of the courier license and retain with tissue documents.
         3) Verification packaging is not damaged.
         4) Verification temperature is within range, if required.
         5) Stamp manufacturer packing slip with stamp provided.
         6) Documentation of condition of product being received.
         7) Place packing slip with completed documentation in materials box at the OR desk.

I inspected the products listed above on receipt and determined for each that the product appearance was acceptable, the container was intact and the label was complete, affixed, and legible

Print Name

Signature Date

Is temp indicator within range? [ ]Yes [ ]No [ ]n/a
Ambient Room Temp (no indicator) [ ]Yes [ ]No

Courier Lic # _____

      iii. OR staff documentation responsibilities:
         1) OR RN will document the implant in patient's electronic health record (EHR). Documentation shall include:
            a) Manufacturer
            b) Description of item implanted
            c) Catalog number

d) Lot and/or serial number
e) Expiration date
f) Type of solution/medication used to rinse/reconstitute
g) Lot number(s) of solution/medication used to rinse/reconstitute
h) Site implanted

2) Copy of implant box showing the item name, catalog number, lot/serial number and expiration date.
3) Place a patient label and implant stickers on Tissue Verification Form and submit the form to the collection box in the OR Bone/Tissue Pyxis.
4) Staple the tissue form and packing slip together and place at the OR desk for collection by the Materials Manager and documentation auditor.

iv. If not all received items are implanted, place the unused items in the OR Bone/Tissue Pyxis.
1) Alert Materials representative of unused items in Pyxis.

v. Materials Manager responsibilities after implantation:
1) Add implanted items into the Tissue and Implant Module (TIM) System.
2) Return unused items to the manufacturer per policy.

vi. TIM Administrative Manager/Surgical RN responsibilities after implantation:
1) Complete TIM documentation.

3. **QUALITY ASSURANCE:**
a. Staff shall submit a Tissue Verification Sheet for each case using tissue implants.
i. Tissue Verification Sheet shall include a patient label and stickers for all tissue implants used.
ii. Tissue Verification Sheets shall be submitted to the collection bin in the OR Tissue Pyxis.
b. A daily report is system generated from Pyxis with of all tissue issued from Tissue Pyxis. The report is reviewed routinely by the Surgery Tissue Administrator/designee, to verify tissue was removed under a patient name, cross-referenced with TIM system to ensure tissue documentation has been completed, and verifying accuracy of lot numbers and expiration dates.
c. Discrepancies are addressed with OR Material Specialist/designee and staff member as needed.

C. **REFERENCES:**
1. AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 06/20

SUBJECT: Autologous Tissue Preservation & Storage

REVISION DATE(S): 06/20

Department Approval:	~~03/20~~08/23
Operating Room Committee Approval:	~~03/20~~02/24
Department of Anesthesiology Approval:	n/a
Department of Pathology Approval:	~~04/20~~03/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~04/24
Administration Approval:	~~06/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **DEFINITIONS:**
1. Autologous tissue: Tissue removed from a patient and stored for future use for transplantation to the same patient.
2. Autotransplantation: Transplantation of tissue from one site to another in the same individual.

B. **POLICY:**
1. Tri-City Medical Center (TCMC) is not a tissue establishment. Autologous tissue collected at TCMC is sent to an off-site tissue storage vendor for storage. Autologous tissue is not stored at TCMC.
2. The patient's autologous tissue (such as cranial bone flap) may be preserved and replanted.
3. Autologous tissues must be preserved and prepared according to tissue storage vendor's specifications.
4. Tri-City Medical Center's autologous tissue storage vendor is California Transplant Services (CTS), Inc, 5845 Owens Avenue, Carlsbad, CA 92008.

C. **PROCEDURE:**
1. Procedure for tissue preservation:
   a. Open the numbered CTS Autologous Tissue Preservation Kit. Review and follow the Instructions for Storage of Autologous Tissue included with the kit. The kit consists of a shipping container with cardboard outer and contains a sterile surgical pack and media.
   b. Per physician order, collect swab cultures of collected tissue and enter Microbiology orders.
2. Use methods to reduce the risk of dropping or contaminating the cranial bone flap, including, but not limited to:
   a. Stabilize the bone flap during elevation, replantation, and drilling processes.
   b. Hold a sterile container below the bone flap elevation and insertion sites.
   c. Designate an area on the sterile field for holding the bone flap steady while drilling.
   d. Transfer the bone flap in a container when moving it from the surgical incision site to the instrument table.
3. Follow surgeon's orders for decontaminating contaminated cranial bone flaps for replantation.
   a. Methods for decontaminating contaminated bone flaps may include:
      i. Mechanical rinse with normal saline solution.

ii. Soaking in normal saline solution for five (5) minutes followed by a one (1) minute mechanical scrub with the bristles of a scrub brush and normal saline solution.
iii. Pulsatile lavage at low-pressure settings (e.g., 6-14 PSI) with normal saline solution.
iv. Processing at a tissue bank.

b. Do not use hydrogen peroxide, chlorhexidine gluconate, or ethanol to decontaminate bone flaps.
c. When decontaminating a cranial bone flap:
i. Use a separate field for decontamination of the flap.
ii. Use interventions to prevent contamination of the sterile field during decontamination (i.e., cover the main sterile field and cover the active hand piece of the pulsatile lavage).
iii. Change gown and gloves after decontamination is complete.
iv. Change the wound classification for the procedure to Class III, Contaminated.
d. Cranial bone flaps may not be sterilized.

4. Reduce the risk of contamination and cross contamination throughout the steps of tissue handling:
a. Transfer autologous tissue intended for preservation off the sterile field as soon as possible.
b. Verify the patient and tissue information verbally with the surgeon using a read-back technique before transferring the tissue from the sterile field.
c. Use standard precautions and sterile technique while transferring autologous tissue from the sterile field.
d. Take measures to prevent contamination of autologous tissue that is on the sterile field including, but not limited to, minimizing handling of the tissue.
5. Keep autologous tissue moist or in solution while it is on the sterile field. Do not place tissue on dry, absorbent surfaces or materials.
6. Clearly label, sequester, and monitor autologous tissue that is kept on the sterile field.

D. **DOCUMENTATION:**
1. Complete the "Autograft Tissue Preservation Service" form (CTS Form 40-2000-1) according to instructions on the form, by completing all known information, or enter the word "no" for unknown items. Information on the form is subject to change per CTS.
a. Name of Patient (required): Enter the patient's name or Trauma name and trauma number.
b. Patient's Medical Record Number (required): Enter the medical record or hospital number.
c. PO#: Obtain and enter the purchase order number, if available.
d. Patient's Sex (required): Check Male (M) or Female (F) for the patient's true biological sex, as applicable.
e. Patient's Age (required): State the patient's age, if known.
f. Date of Birth (DOB): Enter the DOB as MM/DD/YY, if known.
g. Patient's home address or mailing address. This is for purposes of notification and assuring the patient can be notified of the existence and location of the autograft being stored.
h. Name of Hospital (required): Enter the complete name of the hospital. There are many UMC's and Community Hospitals, so we need to know the exact name of the correct facility.
i. Hospital address (required): Provide the street address, city, state, and zip code.
j. Date and Time of Autograft Recovery (required): Enter the date and time the tissue was removed from the patient. This question does not pertain to the start of the surgery.
k. Date and Time placed in Shipper (required): Enter the date and time the tissue was placed in the shipper with wet ice.
l. Informed consent signed? Check Yes (Y) or No (N), or Not Applicable (N/A) as applicable. Include a copy of the operative consent form if obtained.

m. Check Type of Tissue (required). ☐ Skull Flap ☐ Bone ☐ Skin, or ☐ Other (please specify): State the kind of bone or soft tissue recovered, e.g. vertebral body or parathyroid.

n. Antibiotic (required): Answer the question ☐ Y, or ☐ N. If an antibiotic has been administered to the solution used to cover the graft state the kind of antibiotic and dosage in mass/volume.

2. If possible, obtain a PO number for the Tissue Preservation Service and record it on the Autograft Tissue Preservation Form.
3. Obtain the surgeon's signature on the Autograft Tissue Preservation Form.
4. Immediately call California Transplant Services, Inc. for pick-up of the tissue. Toll-free telephone number: (800) 928-4778.
5. Place a copy of the Autograft Tissue Preservation Service Form in the patient's chart.
   a. Place a TIM barcode label in the lower left corner of the form.
   b. Place a patient label in the lower right corner of the form.
6. Make an additional copy of the completed Autograft Tissue Preservation Service Form and submit to the Surgery Materials Manager/Tissue Administrator.
7. Document the autologous tissue explant in the patient's electronic health record (EHR).

E. **FORM(S):**

1. California Transplant Services (CTS), Inc. Autograft Tissue Preservation Service form (CTS Form 40-2000-1).

F. **REFERENCES:**

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.
2. AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.
3. California Transplant Autograft Tissue Preservation Service Instruction Sheet.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 01/05

SUBJECT: Freeze-Dried Room Temperature Tissue

REVISION DATE~~(S)~~: 12/05; 04/09; 05/06; 08/09; 01/13, 06/20

Department Approval:	~~02/20~~08/23
Operating Room Committee Approval:	~~03/20~~02/24
Department of Anesthesiology Approval:	n/a
Department of Pathology Approval:	~~05/20~~03/24
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/20~~04/24
Administration Approval:	~~06/20~~05/24
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **PURPOSE:**
1. To describe the process for the Department of Surgery to order, receive, store, and issue freeze-dried tissue as a satellite location of the Tri-City Medical Center Clinical Laboratory Tissue Bank.

B. **POLICY**:
1. Routine shipments of room temperature tissue, grafts, valves and mesh shall be received and tracked through the Carefusion Tissue and Implant Module (TIM) System according to Surgery Policy "Freeze-Dried Room Temperature Tissue".
2. Tri-City Medical Center is not a source facility. No freeze-dried tissue will be issued outside the hospital, including to surgery centers.

C. **ORDERING FREEZE-DRIED TISSUE:**
1. Surgical Services will complete a Non-Stock Supply Purchase Requisition for all tissue orders. If the tissue is ordered for a specific patient, the requisition must have the patient's name, the physician's name and the date and time of surgery. The completed requisitions are then sent to the Materials Department. All special orders should be placed 48 hours before the scheduled surgery to assure delivery.
2. Tissues must only be ordered from Tissue Banks or Tissue Distribution Centers licensed by the State of California Department of Health Services and registered by the FDA. TCMC Tissue Bank maintains a list of approved vendors.

D. **RECEIVING FREEZE-DRIED TISSUE:**
1. Upon arrival to the hospital, freeze-dried room temperature tissue will be received at the receiving dock.
2. The person receiving the tissue at the receiving dock is responsible for the following:
   a. Verify the shipping container is labeled with the names and addresses of the distributor, TCMC, and any special warnings and/or storage requirements.
   b. Scan the shipping tracking label into the TIM system and place the package onto the TIM workstation in the receiving area.
      i. An email is system generated to a Tissue Receiving Distribution list alerting to the tissue arrival time.
3. The OR Material Specialist/designee is responsible for the following:

a. Verify the packing list has the name and address of the tissue supplier, shows TCMC as the recipient and has a PO number.
b. Compare the packing list to the tissue package to verify identification numbers, expiration dates and storage temperature requirements.
c. Inspect the outside of the tissue package for signs of contamination of the tissue, such as a tear in the package, breakage or discoloration of the tissue.
    i. The package must not be damaged or altered.
    ii. Damaged tissue must not be used.
    iii. Return damaged tissue to the supplier.
d. The OR Material Specialist/designee verifies package integrity was met.
    i. Verification of package integrity is documented in the TIM system.
    ii. The packing slip is sent to the receiving department in Materials Management.
e. The tissue is documented into the TIM system, verifying the following information, as applicable:
    i. Catalog number
    ii. Serial/Lot number
    iii. Expiration date
f. A TIM system IMP label (with a unique identifying number) is generated and attached to each individual tissue package.
g. Tissue is stocked into the OR Bone Bank Pyxis (i.e., Tissue Pyxis) at room temperature.
h. During TIM and/or Pyxis downtime, all packing slips and packaging materials are retained, to be entered into the TIM/Pyxis system at a later date.

E. **STORAGE OF FREEZE-DRIED TISSUE:**

1. The temperature of the Tissue Pyxis must be monitored.
    a. Manual temperature readings are recorded daily onto the Daily Temperature Log, located on the Tissue Pyxis.
    b. If the temperature is out of acceptable range (19-25°C), document date, problem, action taken, and resolution on the Daily Temperature Log.
    c. Notify the Clinical Laboratory Tissue Bank, Materials Management, and Surgical Services Director/Assistant Director/designee immediately if the thermometer readings are outside of the 19-25°C temperature range.
    d. Arrange immediately to move freeze-dried tissue, as directed, to an area of acceptable temperature if out of range.
2. The Daily Temperature Log is reviewed monthly by a member of the Surgical Services leadership team.
3. No tissue will be stored past the tissue expiration date as stated on the tissue package.
    a. A monthly Tissue Expiration Batch Report is system generated monthly and reviewed by the OR Material Specialist/designee.
    b. Tissue approaching expiration date is removed from Pyxis inventory and documented in TIM system as discarded. Tissue is discarded in biohazardous waste.
4. Tri-City Medical Center is not a source facility. No freeze-dried tissue will be issued outside the hospital.

F. **OBTAINING AND IMPLANTING FREEZE-DRIED TISSUE:**

1. The OR Registered Nurse (RN)/designee will log into the Tissue Pyxis, and select the appropriate patient.
    a. If the patient is not on the list, contact the OR Material Specialist/designee to add the patient.
2. The OR RN/designee will remove the selected tissue from the Pyxis and inspect the package for integrity and visible signs of contamination.
3. The OR RN/designee will select the appropriate tissue and press the "take" button.
    a. Scan the TIM label on each package removed after pressing "take".
    b. If the scanner is unavailable or not functioning, manually enter the IMP number into the Pyxis.

4. All tissue will be transported, handled, prepared, stored and used according to the source facilities or manufacturer's instructions for use (IFU).
   a. Documentation shall include preparation methods, per manufacturer's IFU, including lot numbers, serial numbers, and expiration dates of solutions/medications used to prepare the tissue, as applicable.
5. The documentation accompanying the tissue must be reviewed for the results of non-reactive serologic testing for the appropriate infectious diseases.
6. If applicable, the Circulating Nurse will verify that a package insert containing a statement indicating the donor has been screened and found non-reactive by laboratory tests for evidence of infection with HIV (HIV 1 and HIV 2), agents of viral hepatitis (HBV and HCV), human T lymphotrophic virus-1 (HTLV-1) and syphilis is with the tissue. If no insert is found, call the facility and ask if the appropriate testing has been performed and has non-reactive results. The package insert must also contain instructions for proper handling, storage, transport and use/reconstituting of the tissue. If no insert is found, call the supplier and ask them to fax the required testing results and instructions STAT.
   a. Tissues received without required negative testing results or with reactive test results, will not be used for implantation at TCMC.
   b. When the fax is received attach it to the product.
   c. If the supplier cannot fax the required documentation, the tissue must be returned to the supplier.
7. After implantation of tissue into the patient, the Circulating RN completes the documentation in the Carefusion TIM application.
   a. In the event of TIM application downtime, document the tissue implant in the implant section of the patient's electronic health record.
   b. The Circulating RN will complete the tissue tracking form from the manufacturer, if applicable, and return the paperwork to the OR Material Specialist/designee at the end of the case.
8. The OR RN shall complete a Surgery Tissue Implant Verification Form (located in Tissue Pyxis) with a patient label and labels from each implanted tissue. Return completed Tissue Implant Verification Forms to the Tissue Pyxis.
9. If the freeze-dried tissue is opened but not used, the OR RN will complete TIM documentation, noting the tissue was discarded, and complete a Tissue Tracking Card. Dispose of the tissue in the biohazardous waste container.
   a. Notify the Surgery Biller/designee the tissue was opened but not used.

G. **RETURNED FREEZE-DRIED TISSUE:**

1. Freeze-dried room temperature stored tissue may be returned to the Pyxis for reissue if the tissue is in its original unopened, sterile container and the storage temperature requirements of the tissue have been maintained.
2. Inspect the tissue package to ensure that it is still sealed and all documentation issued with the tissue has also been returned.
3. The Circulating Nurse will log into the Tissue Pyxis and select the correct patient, push the appropriate "return" button and scan the IMP label on the tissue package. Return the tissue to the appropriate bin and close the door of the Pyxis. Repeat this process for each tissue returned and exit from the Pyxis.

H. **QUALITY ASSURANCE:**

1. Staff shall submit a Tissue Verification Sheet for each case using tissue implants.
   a. Tissue Verification Sheet shall include a patient label and stickers for all tissue implants used.
   b. Tissue Verification Sheets shall be submitted to the collection bin in the OR Tissue Pyxis.
2. A daily report is system generated from Pyxis with of all tissue issued from Tissue Pyxis. The report is reviewed routinely by the Surgery Tissue Administrator/designee, to verify tissue was removed under a patient name, cross-referenced with TIM system to ensure tissue documentation has been completed, and verifying accuracy of lot numbers and expiration dates.

3. Discrepancies are addressed with OR Material Specialist/designee and staff member as needed.

I. **REPORTING OF ADVERSE REACTION TO FREEZE-DRIED TISSUE:**

1. All adverse outcomes of tissue implantation must be reported to the Clinical Laboratory Tissue Bank and Risk Management. These adverse outcomes may include, but are not limited to:
   a. Infections
   b. Tissue failures
   c. Other quality issues
2. The following information must be acquired from the person reporting the adverse outcome and sent to the Clinical Laboratory Tissue Bank within 24 hours of notification on a quality review report via the RL system. The Clinical Laboratory Tissue Bank/designee will promptly report the following to the source facility, as applicable:
   a. Patient name
   b. Patient Medical Record Number (MRN)
   c. Implanting physician's name
   d. Type of tissue implanted
   e. Date of the implant
   f. Date the adverse outcome is being reported
   g. Patient symptoms
   h. Name of the person reporting the adverse reaction
   i. Name of the person obtaining the information
   j. Date the report was obtained

J. **RECALL OF FREEZE-DRIED TISSUE:**

1. The tissue supplier will notify TCMC when a tissue has been recalled.
2. If the tissue has not been issued, send the tissue to the OR Material Specialist/designee for quarantine immediately.
3. If the tissue has been issued, obtain the following information and send to Risk Management within 24 hours of notification and complete a quality review report via the RL system.
   a. Patient name
   b. Patient Medical Record Number (MRN)
   c. Implanting physician's name
   d. Type of tissue implanted
   e. Date of the implant
   f. Date the recall was received
   g. Reason for the recall
   h. Patient symptoms, if any
   i. Name of the company issuing the recall
   j. Name of the person obtaining the information

K. **RECORDS:**

1. TCMC records permit tracing of any tissue from the supplier to the recipient or to final disposition or discard.
2. All records are maintained electronically or hard copy (in storage) for at least 10 years from the date of implantation or date of tissue expiration/disposition as applicable.

L. **REFERENCES:**

1. AABB. (2008). Hospital Tissue Management: A Practitioner's Handbook, First Edition.

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

May 2, 2024 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on May 2, 2024.

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

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

Absent: Director Gigi Gleason

Also present were:

Dr. Gene Ma, Chief Executive Officer
Jeremy Raimo, Chief Operating Officer
Henry Showah, M.D., Chief of Staff
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Chairperson, Director Tracy M. Younger. called the meeting to order at 2:30 p.m. with attendance as listed above.

2. Approval of Agenda

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

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

   Chairperson Younger made an oral announcement of the items listed on the May 2, 2024 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets.

6. Motion to go into Closed Session

   It was moved by Director Chavez and seconded by Director Coulter to go into Closed Session at 2:35 p.m. The motion passed (6-0-0-1) with Director Gleason absent.

7. At 3:30 p.m. the Board returned to Open Session with attendance as previously noted.

8. Report from 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 Amendment Two (2) to the Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, dba Orthopedic Specialists of North County.

It was moved by Director Chaya to approve Amendment Two (2) to the Professional Services Agreement between Tri-City Healthcare District and Tri-City Orthopedic Surgery Medical Group, dba Orthopedic Specialists of North County. Director Chavez seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

10. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:30 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
George Coulter
Assistant Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
May 2, 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 May 2, 2024.

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

Director Nina Chaya, M.D.
Director George W. Coulter
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent: Director Rocky J. Chavez
Director Gigi Gleason

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
Mark Albright, Chief Information Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

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

2. Report from Closed Session

   Board Counsel Scott reported the Board in Closed Session discussed a Trade Secret matter and took no action.

3. Pledge of Allegiance

   Director Younger led the Pledge of Allegiance.

4. Approval of Agenda

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

5. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the March 28, 2024 Regular Board of Directors Meeting Agenda.

6. March, 2024 Financial Statements – Janice Gurley, Chief Financial Officer

Janice Gurley, Chief Financial Officer reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $215,520
- Operating Expense – $247,905
- EBITDA – ($10,547)
- EROE – ($24,398)

Janice reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 114
- Adjusted Patient Days – 59,877
- Surgery Cases – 3,644
- ED Visits – 32,879

Janice reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $26,849
- Operating Expense – $27,290
- EBITDA – $1,846
- EROE – $241

Janice reported on the current month Key Indicators as follows:

- Average Daily Census – 126
- Adjusted Patient Days – 7,284
- Surgery Cases – 490
- ED Visits – 3,773

Janice noted this is the third consecutive positive month and is a tribute to everyone who has worked so hard controlling expenses and flexing to volume.

Lastly, Janice reported the cyber incident in November had a $7.1 million impact on the financials.

7. New Business –

a) Approval of the renewal of an agreement with Nandan Prasad, M.D., as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning May 1, 2024 and ending April 30, 2025, not to exceed a total term cost of $51,500.

It was moved by Director Chaya to approve the agreement with Nandan Prasad, M.D. as the Medical Director of Quality/Chairperson of Medical Quality Peer Review Committee for a term of 12 months, beginning

May 1, 2024 and ending April 30, 2025. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

8. Old Business -

a) Affiliation Update –

Dr. Ma stated the due diligence process continues.

9. Chief of Staff –

Dr. Henry Showah, Chief of Staff stated the April Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals are presented for information only and were approved electronically due to the April 30, 2024 deadline.

10. Consideration of Consent Calendar

It was moved by Director Sanchez to approve the Consent Agenda as presented. Director Mizell seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

11. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

12. Comments by Members of the Public

There were no comments from members of the public.

13. Comments by Chief Executive Officer

Dr. Ma reported construction on the Emergency Department remodel has begun and completion is projected in 9-12 months.

Dr. Ma also provided some fiscal year highlights which included an increase in average daily census, total surgeries, Acute Rehab census and total admissions. He noted April is trending in an even more positive direction.

Dr. Ma expressed disappointment in comments that were made by the nursing union recently regarding lack of support. Dr. Ma emphasized that we are committed to bringing in front line nurses to provide breaks and lunches. He stated we have hired and oriented 163 nurses since January of last year. In addition, we have 62 new RN postings and have added 15 new grad positions for an August 19th start. Dr. Ma also commented that we have decreased our Travelers in one year from well over 100 to less than 10. Total contract labor spend is 30% of what it was at the end of the first pay period for FY 2024. Those statistics mean more union jobs and more permanent employees.

Dr. Ma reported next week (May 6-12) we will celebrate Nurse's Week, followed by overlapping Hospital Week. The team has been preparing celebratory events to let our staff know how much we value and appreciate them. Dr. Ma thanked the nurse's in the room today for all they do and wished them a happy Nurse's Week.

Lastly, Dr. Ma reminded everyone of the upcoming Golf Tournament on June 24th at Fairbanks Ranch. Contact the Foundation for more information!

14. Board Communications

Director Younger wished hospital staff happy Nurse's Week and Hospital Week.

15. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 3:53 p.m.

_____
Tracy M. Younger
Chairperson

ATTEST:

_____
George Coulter
Assistant Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending April 30, 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)	54,257.88	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)	38,137.94	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)	11,088.83	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 Calrsbad** 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				**242,059.29**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending April 2024

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	Charge	32824 EDU	200.00	79190	STEPHENSON, JENNIFER

**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.