TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
July 30, 2015 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
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	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators (Authority: Government Code Section 54957.6) Agency Negotiator: Tim Moran Employee organization: SEIU		
	b. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	c. Conference with Legal Counsel – Potential Litigation (Authority Government Code Section 54956.9(d) (2 Matters)		
	d. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	e. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: October 31, 2015		
	f. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: August 27, 2015		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	g. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2015		
	h. Conference with Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 (1) Lockton Companies vs. TCHD Case No. 37-2015-00013956-CU-BC-NC (2) John Young, M.D. vs. TCHD Case No. 37-2009-00099935-CU-WM-NC		
	i. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	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 14-018, 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
12	Introductions: Cheryle Bernard-Shaw – Chief Compliance Officer Dr. Gene Ma – Chief of Staff	5 min.	Chair
13	Special Recognitions – 1) NICU – 5 years CLABSI Free – Nancy Myers, Manager, NICU and Dr. Hamid Movahhedian 2) Robert Veluz – USD MEPN Program "Preceptor of the Year" award	5 min. 5 min.	S. Schultz S. Schultz
14	Report from TCHD Auxiliary	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Chief Financial Officer	10 min.	Standard
17	New Business a. Consideration to approve Resolution No. 774, A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents Related to Tri-City Medical Center and Other Affiliated Entities	5 min.	Gov. & Leg. Comm.

	Agenda Item	Time Allotted	Requestor
18	Old Business a. Nifty After Fifty Update	15 min.	CEO/CMO
19	Chief of Staff a. Consideration of July 2015 Credentialing Actions Involving the Medical Staff – New Appointments Only b. Medical Staff Credentials for July, 2015	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 2 *No meeting held in July, 2015* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in July, 2015* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats - 1 *No meeting held in July, 2015* **D. Finance, Operations & Planning Committee** Director Dagostino, Committee Chair Open Community Seats – 0 *No meeting held in July, 2015* **E. Professional Affairs Committee** Director Dagostino, Committee Chair (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Patient Care Services Policies and Procedures**: a. Communication with the Sensory Impaired and-or Persons with Language Barriers b. Dialysis, Acute Treatment of the Inpatient Policy c. Hemodialysis, Care of Patient Procedure – (DELETE) d. Emergency Department Admission Standardized Procedure e. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure f. Infusion Pump Syringe or PCA Module System with Guardrails Procedure g. Infusion Pumps, Intravenous Therapy Policy	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm. PAC Comm.

	Agenda Item	Time Allotted	Requestor
	h. Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Standardized Procedure i. Pain Management Policy i. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure k. Restraints Used for Non-Violent Self-Destructive Behavior Policy l. Restraint Seclusion for Violent, Self Destructive Behavior Policy 2) **Unit Specific** **1. Neonatal Intensive Care Unit** a. Car Seat Challenge Test **2. Women and Newborn Services** a. Car Seat Challenge Test (DELETE) **3. Emergency Operations Procedures Manual (formerly Disaster Manual) Section 3: Special Circumstances** a. Code Silver Person with Weapon or Active Shooter **4. Pharmacy** a. Chemotherapy, Prescribing, Processing and Preparation b. Clinical Intervention Activity Documentation Program c. Clinical Protocol Drug Therapy Consults (DELETE) d. Completion of Therapeutic Drug Monitoring Profiles (DELETE) e. Controlled Substances (DELETE) f. Controlled Substances – Pharmacy g. Digifab Use in Digoxin Toxicity (DELETE) h. Floor Stock i. Licensure and Professional Standards j. Medication Orders (Pharmacy) (DELETE) k. Medication Preparation l. Pharmacists Therapeutic Intervention (DELETE) m. Pharmacy Range Order Policy (DELETE) n. Poison Control (DELETE) o. Prescribing Ordering - General Practices (DELETE) p. Procurement of Medications (DELETE) q. Questionable Medication Orders (DELETE) r. Radioactive Medications (DELETE) s. Restricted Antimicrobials t. Self Administration of Medications by Patients and Non Staff Members (DELETE) u. Succimer (Chemet) in Lead Poisoning (DELETE) v. Technician Checking Technician Program w. Therapeutic Drug Monitoring (DELETE) x. Unlabeled Uses of FDA-Approved Medications y. Unusable and Outdated Drugs		

	Agenda Item	Time Allotted	Requestor
	3) **Pre-Printed Orders** a. Inpatient Pre-Surgical AM Orders b. Outpatient Pre and Post-Operative Orders **F. Governance & Legislative Committee** Director Schallock, Committee Chair Open Community Seats - 0 (Committee minutes included in Board Agenda packets for informational purposes.) 1) **Rules & Regulations** a. Division of Internal Medicine b. Department of Anesthesiology c. Department of General & Vascular Surgery 2) Approval of Board Policy 14-043 External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms. 3) Approval of Board Policy 14-031 Members on Board Committees, Conflict of Interest 4) Approval of Board Policy 14-029 Protest or Demonstration on District Property Outside of Public Meetings. **G. Audit & Compliance Committee** Director Finnila, Committee Chair Open Community Seats – 1 *No meeting held in July, 2015* (2) Minutes – Approval of a) June 25, 2015 – Regular Board of Directors Meeting b) June 30, 2015 (Adjourned from June 25, 20150 – Regular Board of Directors Meeting (3) Meetings and Conferences – 2015 Basic Compliance Academics -- October 19-22, 2015 Las Vegas, NV **OR** November 30-December 3, 2015 -- San Diego, CA (4) Dues and Memberships - None		Gov. & Leg. Comm. Audit, Comp. & Ethics Comm. Standard Standard Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard - Included (b) Construction Report – None (c) Lease Report -- (June, 2015) (d) Reimbursement Disclosure Report – (June, 2015) (e) Seminar/Conference Reports - None	0-5 min.	Standard
23	Legislative Update	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board.	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session **(Includes 10 minutes for recess to accommodate KOCT tape change)**	**2 hours/ 10 min.**	
28	Oral Announcement of Items to be Discussed During Closed Session (If Needed)		
29	Motion to Return to Closed Session (If Needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) -- (If Needed)		
32	Adjournment		

University of San Diego
HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

5998 Alcala Park
San Diego, CA 92110-2492
www.sandiego.edu

June 23, 2015

Dear Robert,

Congratulations, you have been selected as the University of San Diego **MEPN Preceptor of the Year.** MEPN students were asked to identify attributes in his/her preceptor which made the preceptor someone special. Recent MEPN graduate, Christine Richardson, wrote a very thoughtful nomination about why you should be the winning preceptor.

You will receive your award and be honored at our Placement Appreciation Dinner in November. Details about the dinner will be sent to you in early September. We hope you will be able to attend so we can thank you in person for your extraordinary work.

Clinical experience with expert clinical preceptors in a variety of settings is a vital part of the education of our nursing students. We are so grateful that through your involvement, our academic education curriculum has been complemented by your clinical expertise. Your time and talent, which you have provided as a preceptor, has strengthened the students' clinical nursing knowledge and skills. As you witness these students progressively integrating and strengthening this knowledge and their newly acquired skills, please know that you have played a large part in their clinical learning and role development.

We sincerely hope that you will continue to participate as a preceptor and provide your invaluable contribution to the clinical education of our future nurses.

Warm regards,

Kathy Marsh

Kathy K. Marsh, PhD, RN
Associate Professor & MEPN Program Coordinator
University of San Diego Hahn School of Nursing and Health Sciences

Mail to: kathymarsh@sandiego.edu

RESOLUTION NO. 774

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT CONFIRMING THE NAME USED BY THE DISTRICT IN CONTRACTS AND OTHER DOCUMENTS RELATED TO TRI-CITY MEDICAL CENTER AND OTHER AFFILIATED ENTITIES

WHEREAS, Tri-City Healthcare District (the "District") owns and operates the Tri-City Medical Center (the "Hospital") under the terms of the Local Health Care District Law of the State of California (H&S Code §32000 *et seq.*); and

WHEREAS, the District is a public entity, and in accordance with Government Code, § 7530, identifies itself as a public entity when required and appropriate; and

WHEREAS, the District enters into contracts related to the Hospital, and is identified in various documents related to the Hospital; and

WHEREAS, the District also enters into contracts related to other facilities associated with the District and the Hospital, including the Tri-City Wellness Center, Tri-City Medical Office Building, and Tri-City Primary Care Clinic, and is identified in various documents related to those associated facilities; and

WHEREAS, the Board of Directors of the District desires to create a standard name to be used by the District in contracts and other documents related to the Hospital and other facilities associated with the District and Hospital;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the District:

Section 1. That in all contracts entered into by the District related to the Hospital, and in all documents wherein the District is identified in relation to the Hospital, the District shall be identified by the following name, "Tri-City Healthcare District, a public entity, on behalf of Tri-City Medical Center."

Section 2. That in all contracts entered into by the District related to the Tri-City Wellness Center, the Tri-City Medical Office Building, and/or the Tri-City Primary Care Clinic, and in all documents wherein the District is identified in relation to those facilities, the District shall be identified by the following name, "Tri-City Healthcare District, a public entity", or "Tri-City Healthcare District, a public entity, on behalf of Tri-City Medical Center", as appropriate.

ADOPTED, PASSED AND APPROVED this ___ day of July, 2015, at a _____ meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:

NOES:

ABSTAIN/ABSENT:

By:_____
Chairperson, Board of Directors

ATTEST:

By:_____
Secretary, Board of Directors

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
July 8, 2015

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 07/31/2015 – 06/30/2017)
Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 07-31-15 through 06-30-2017:

CHOI, James J., MD / Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

DEPALA, Venugopal, MD / Psychiatry
Recommend appointment to the Provisional staff with privileges in Psychiatry as delineated on the privilege card **WITH** proctoring for all privileges.

IPSON, Jason T., MD / Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

LAU, Kenneth K., MD / Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

MCGRAW, Charles J. Jr., MD / Interventional Radiology
Recommend appointment to the Provisional staff with privileges in Interventional Radiology as delineated on the privilege card **WITH** proctoring for all privileges.

NARLA, Vinod V., MD / Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

NIZAMANI, Saifullah, MD /Psychiatry
Recommend appointment to the Provisional staff with privileges in Psychiatry as delineated on the privilege card **WITH** proctoring for all privileges.

PAL, Joshua S., MD / Anesthesiology
Recommend appointment to the Provisional staff with privileges in Anesthesiology as delineated on the privilege card **WITH** proctoring for all privileges.

WILLIAMS, Kristin, MD /Maternal & Fetal Medicine
Recommend appointment to the Provisional staff with privileges in Maternal and Fetal Medicine as delineated on the privilege card **WITH** proctoring for all privileges.

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFSSIONAL STAFF
The following practitioner has applied for Allied Health Professional status. Following review of the practitioner's files and all required documentation, the committee voted to recommend appointment to the Allied Health Professional Staff with practice prerogatives as delineated on the privilege card with proctoring for all privileges:

ALLEN, Matthew, PA-C

Physicians Assistant in the Emergency Department (s): Dr. Neil Tomaneng sponsoring physician.
Initial to AHP staff with practice prerogatives as reflected on the prerogatives card WITH proctoring.

HERMANSON, Kathleen, PA-C
Physicians Assistant in the Emergency Department (s): Dr. Gregory Sahagian sponsoring physician.
Initial to AHP staff with practice prerogatives as reflected on the prerogatives card WITH proctoring.

INITIAL APPLICATION WITHDRAWAL: (Voluntary unless otherwise specified)
Medical Staff:
None

Allied Health Professionals:
None

TEMPORARY PRIVILEGES: Medical Staff/Allied Health Professionals:
None

TEMPORARY MEDICAL STAFF MEMBERSHIP: Medical Staff:
None

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
July 8, 2015

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 08/01/2015 – 07/31/2017)
The following applications were recommended for reappointment to the medical staff office effective 8/1/2015 through 7/31/17, 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:

ADHANOM,Teamrat A., MD/Internal Medicine/Medicine/Active
Recommend reappointment to Active staff with privileges in Internal Medicine as delineated on the privilege card WITH continued proctoring.

Note: Physician remains on proctoring for Moderate Sedation 2 cases are needed.

ANTHONY, Julian N., MD/Urology/Surgery/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Internal Medicine as delineated on the privilege card WITHOUT proctoring.

COLANGELO, Caroline J., MD/Urology/ Surgery/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Urology as delineated on the privilege card WITH continued proctoring.

Note: Physician remains on proctoring for Robotic Surgery - Multiple Port (da Vinci) 3 cases are needed; CO2 laser Initial 1 case is needed; Greenlight laser (diode) 1 case is needed; Sacral nerve stimulation Initial 1 case is needed; and Renal laparoscopy 3 cases are needed. Also, physician relinquished the Moderate Sedation privilege.

CORONA, Frank E., MD/Pulmonary/Medicine/Active
Recommend reappointment to Active staff with privileges in Pulmonary Medicine as delineated on the privilege card WITHOUT proctoring.

CURRAN, Perrin J., MD/Internal Medicine/Medicine/Active
Recommend reappointment from Active staff to Courtesy staff with privileges in Internal Medicine as delineated on the privilege card WITHOUT proctoring.

FOLKERTH, Theodore L., MD/Cardiothoracic Surgery/Surgery/Active
Recommend reappointment to Active staff with privileges in Cardiothoracic Surgery as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for Moderate Sedation 2 cases are needed; and Deep Sedation 2 cases are needed.

Relinquish – Assist in Robotic Surgery (da Vinci)

GUITERREZ, Miguel A., MD/Emergency Medicine/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Emergency Medicine as delineated on the privilege card WITH proctoring.
Note: Physician remains on proctoring for Moderate Sedation 2 cases are needed; and Deep Sedation 2 cases are needed.

HIGGINS, Steven L., MD/Cardiology/Medicine/Active
Recommend reappointment to Active staff with privileges in Cardiology as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for Moderate Sedation 2 cases are needed; and Moderate Sedation Post-Completion Test Proctoring 2 cases are needed.

IWAOKA, Ken R., MD/Family Medicine/Family/Active
Recommend reappointment to Active staff with privileges in Family Medicine as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for consultation; cardiac rehab locations 2 cases are needed.

KAO, Jerry., MD/ Pathology Anatomic/Pathology/Active
Recommend reappointment to Active staff with privileges in Pathology – Anatomic as delineated on the privilege card WITHOUT proctoring.

KASED, Norbert, MD/ Radiation Oncology/Medicine/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Radiation Oncology as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for Teletherapy 1 case is needed.

KOCH, Richard A., MD/ Emergency Medicine/Emergency Medicine/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Emergency Medicine as delineated on the privilege card WITHOUT proctoring.

MA, Gene, MD/ Emergency Medicine/Emergency Medicine/Active
Recommend reappointment to Active staff with privileges in Emergency Medicine as delineated on the privilege card WITHOUT proctoring.

MARQUART, Elizabeth O., MD/ Emergency Medicine//Emergency Medicine Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Emergency Medicine as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for limited abdominal and cardiac ultrasonography 25 cases are needed; moderate sedation 2 cases are needed; deep sedation 2 cases are needed; and limited abdominal and cardiac ultrasonography 25 cases are needed.

MAZUR, Paul A., MD/ Cardiothoracic Surgery/Surgery/Active
Recommend reappointment to Active staff with privileges in Cardiothoracic Surgery as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for Deep Sedation 2 cases are needed; and Moderate Sedation 2 cases are needed.

Relinquish – Laser Surgery

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
July 8, 2015

OH, Irene, MD/Neurology/Medicine/Active
Recommend reappointment to Active staff with privileges in Neurology as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for lumbar puncture 1 case is needed; and admit patients initial in-hospital 6 cases are needed.

PARK, Sue Ann, MD/Pediatrics/Pediatrics/Active
Recommend reappointment to Active staff with privileges in Pediatrics as delineated on the privilege card WITHOUT proctoring.

PREGERSON, David B., MD/ Emergency Medicine/Emergency Medicine/Active
Recommend reappointment to Active staff with privileges in Emergency Medicine as delineated on the privilege card WITHOUT proctoring.

REISMAN, Bruce K., MD/ Otolaryngology/Surgery/Active
Recommend reappointment to Active staff with privileges in Otolaryngology as delineated on the privilege card WITHOUT proctoring.

SCHEINBERG, Robert S., MD/ Dermatology/Medicine/Consulting
Recommend reappointment to Consulting staff with privileges in Dermatology as delineated on the privilege card WITHOUT proctoring.

SHIN, Heamin T., DPM/ Podiatric Surgery/Surgery/Active
Recommend reappointment to Active staff with privileges in Podiatric Surgery as delineated on the privilege card WITHOUT proctoring.

STEWART, Ryan W., MD/ Internal Medicine/Medicine/Courtesy
Recommend reappointment from Courtesy to Affiliate staff non-clinical privileges in Internal Medicine as delineated on the privilege card WITHOUT proctoring.

Note: Physician relinquished Admit patients, Consultations, History and Physical examination, and Read EKGs/supervise treadmill EKGs. Physician requested to add Refer and Follow, which means he will refer patients to the hospital and follow their progress, but an attending physician would provide necessary care.

ZHONG, Yan, MD/ Internal Medicine/Medicine/Provisional
Recommend reappointment from Provisional staff to Active staff with privileges in Internal Medicine as delineated on the privilege card WITH proctoring.

Note: Physician remains on proctoring for admit patients Internal Medicine 6 cases needed.

BIENNIAL REAPPOINTMENTS ALLIED HEALTH PROFESSIONALS:
The following practitioner has applied for Allied Health Professional status. Following review of the practitioner's files and all required documentation, the committee voted to recommend appointment to the Allied Health Professional Staff with practice prerogatives as delineated on the privilege card with proctoring for all privileges:

SHUFORD, Scott A., MD/ Nurse Practioner/Medicine/Active
Recommend for reappraisal of Allied Health Professional with delineation of duties as included.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
July 8, 2015

Attachment B

RESIGNATIONS: (Effective date 07/31/2015 unless otherwise noted)
Voluntary:

Barrus, Adam B., MD	Anesthesiology **(Effective 06.30.2015)**
Federhart, Jay, MD	Radiology **(Effective 06.25.2015)**
Hwang, Sara E.,	Emergency Medicine **(Effective 06.25.2015)**
Latendresse, Thomas R, MD	Anesthesiology **(Effective 06.30.2015)**
Sherer, Edward H., MD	Anesthesiology
Zelonis-Shou, Beth A., MD	Emergency Medicine

JUNE 2015 CREDENTIALS REPORT DATE CORRECTION

REAPPOINTMENTS: (Effective Dates 07/01/2015 – ~~07/31/2017~~ **06/30/2017**)

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
July 8, 2015

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS (Effective Date: 07/30/2015, unless specified otherwise)

NONE

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
June 10, 2015

PROCTORING RECOMMENDATIONS (Effective 06/25/2015, unless otherwise specified)

NONE

Human Resources Committee (No meeting held in July, 2015)

Employee Fiduciary Subcommittee
(No meeting held in
July, 2015)

Community Healthcare Alliance Committee (No meeting held in July, 2015)

Finance, Operations & Planning Committee (No meeting held in July, 2015)

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
July 16, 2015

Members Present: Director Laura Mitchell (Acting Chair), Director Ramona Finnila, Dr. Gene Ma, Dr. James Johnson, Dr. Scott Worman and Dr. Marcus Contardo.

Non-Voting Members Present: Tim Moran, CEO, Kapua Conley, COO/ Exec. VP and Sharon Schultz, CNE/Sr. VP.

Others present: Jody Root, General Counsel, Cheryle Bernard-Shaw, Chief Compliance Officer, Jami Piearson, Director of Quality and Regulatory, Jeremy Raimo, Steve Young, Patricia Guerra, Kathy Topp, Jeff Surowiec, Tori Hong, Sharon Davies and Karren Hertz.

Members absent: Board Chair Director Dagostino.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell, called the meeting to order at 12:07 p.m. in Assembly Room 1. *Director Mitchell acknowledged the presence of Dr. Ma as it is his first time to sit in this committee as the newly-appointed Chief of Staff. Dr. Worman was also given recognition for his work and support of this committee for the past two years.		Director Mitchell
2. Approval of Agenda	The group reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Director Finnila and seconded by Dr. Ma.	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell
4. Ratification of minutes of June 2015.	Director Mitchell called for a motion to approve the minutes of the June 18, 2015.	Minutes ratified. Director Mitchell moved and Dr. Ma seconded the motion to approve the minutes from June 2015.	Karren Hertz
5. New Business a. Quality Outcomes Dashboard	The committee reviewed the dashboard for Core Measures data. Jami briefly discussed the fall issues as well as how the hospital is diligently monitoring the influenza immunization, VTE prophylaxis, median time from ED arrival to ED departure for admitted ED patients and LWOTs among others.	Informational. **ACTION:** Jami will be presenting the Hospitals Compare data for next month.	Jami Piearson
Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:**	*Patricia Guerra once again made a clarification on the difference between LIP and Allied Health Professionals as mentioned in most of the policies to be discussed in this meeting.		
1. Communication with the	Director Finnila posed a question regarding	**ACTION:** The Patient Care	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Sensory Impaired and-or Persons with Language Barriers	the master list for the interpretation services that the hospital utilizes. Sharon Schultz mentioned that we used 2 companies and they send staff people as we do not use machines for interpretation services.	Services policies and procedures were approved with the exception of some minor edits. Director Finnila moved and Dr. Worman seconded the motion to approve these policies.	
2. Dialysis, Acute Treatment of the Inpatient Policy	The word "incapacitated" in the 1st page will be modified. It was also stated that the dialysis nurse is not part of the hospital staff but this person undergoes the training and competencies just like what our staff does.		
3. Hemodialysis, Care of Patient Procedure	No discussion on this policy.		
4. Emergency Department Admission Standardized Procedure	There was a minor correction on the premise of the physician being delayed in initiating or completing standardized procedure. Vaginal bleeding on page 256 was also modified to add "known pregnancy" on the section title.		
5. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure	This policy aims to identify HIV-infected patients although the Infection Control Dept. guides the whole process.		
6. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	*Format correction on b section title.		
7. Infusion Pumps, Intravenous Therapy Policy	There was a small discussion regarding back flushing technique. It was also clarified that there needs to be a separate IV line for		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	potential incompatibilities.		
8. Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Standardized Procedure	*Editorial correction on the 1st page on the patient population to be tested for MRSA. The term "using a selective agar plate" was deleted as recommended by Dr. Johnson.		
9. Pain Management Policy	After a detailed discussion on the assessment of pain level and what shall be done after PO intervention, 1- 2 hours timeframe remained as is in the policy. The word "shall" will be changed to "should" to comply with the JC mandates.	**ACTION:** The horizontal display outline to describe a patient's pain level will be changed to vertical in the ED boards.	Patricia Guerra
10. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	This policy is exclusive for CAT-Scan purposes and not for PICC line process.		
11. Restraints Used for Non-Violent Self-Destructive Behavior Policy	The restraints mentioned in this policy are meant to be used "to guide" and not restrict patients. Practitioners should be used for this policy and not physicians (only for this policy).		
12. Restraint Seclusion for Violent, Self Destructive Behavior Policy	It was identified that there are currently no concerns for sitters when it comes to patients that need restraints. There is also a video beings used for patients although it can be an adjunct but not meant to replace physical checks done in the units.		
Administrative Policies			
1. Incident Report-Quality Review Report (QRR)	This policy is being pulled for further review of Marcia Cavanaugh and Jody Root.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Unit Specific			
Neonatal Intensive Care Unit 1. Car Seat Challenge Test	This policy was restructured to reflect NICU population.	**ACTION:** The Unit Specific policies for NICU and WNS were approved and is going forward for Board approval as moved by Dr. Worman and seconded by Director Mitchell.	Patricia Guerra
Women and Newborn Services 1. Car Seat Challenge Test	*Policy deleted.		
Emergency Operations Procedures Manual (formerly Disaster Manual) **Section 3: Special Circumstances** 1. Code Silver Person with Weapon or Active Shooter	Discussion entailed on persons with concealed weapons not allowed in the hospital; Kapua also reiterated that all staff is trained in Net learning, mandatory for some (like Security) and also, there is an upcoming drill in August on the issue of weapons. For brandishing, Security will be alerted but not all staff. Metal detectors in the ED is not ideal. On such situations, law enforcement will take over once they arrived the hospital.	**ACTION**: This policy was approved as moved by Dr. Contardo and seconded by Dr. Worman.	
Pharmacy 1. Chemotherapy, Prescribing, Processing and Preparation 2. Clinical Intervention Activity Documentation Program	The word TCMC shall be changed to TCHD on the 1st page of this policy.	**ACTION:** The Pharmacy policies were approved with the exception of the policy on patient specific information and are going forward for Board approval as moved by Dr. Contardo and	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Clinical Protocol Drug Therapy Consults		seconded by Director Finnila.	
4. Completion of Therapeutic Drug Monitoring Profiles			
5. Controlled Substances	Controlled substances are kept in carts but not in automated medicine cabinets.		
6. Controlled Substances – Pharmacy	Tori Hong clarified that TCMC as a facility still have to apply for a license for DEA although, they do not go onsite, unless there is an issue.		
7. Digifab Use in Digoxin Toxicity			
8. Floor Stock			
9. Licensure and Professional Standards	It was reported that these standards are dictated by the State Board of Pharmacy.		
10. Medication Orders (Pharmacy)			
11. Medication Preparation	Tori clarified that any medication that is a sterile compound is compounded under the hood.		
12. Patient Specific Information	This policy is being pulled out for further review.		
13. Pharmacists Therapeutic Intervention			
14. Pharmacy Range Order			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy 15. Poison Control	This policy is also tied up with the antidote policy.		
16. Prescribing Ordering - General Practices			
17. Procurement of Medications			
18. Questionable Medication Orders			
19. Radioactive Medications			
20. Restricted Antimicrobials			
21. Self Administration of Medications by Patients and Non Staff Members			
22. Succimer (Chemet) in Lead Poisoning			
23. Technician Checking Technician Program	This is considered a standard process, not punitive and not intimidating.		
24. Therapeutic Drug Monitoring			
25. Unlabeled Uses of FDA-Approved Medications	The hospital does not keep a list of unapproved meds, only if something comes up.		
26. Unusable and Outdated	Unusable and outdated drugs are		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Drugs **Pre-Printed Orders** 1. Inpatient Pre-Surgical AM Orders 2. Outpatient Pre and Post-Operative Orders	quarantined in the pharmacy and a third party company picks them up. Kathy Topp mentioned that these pre-printed orders have gone through all the reviewing committees. The DVT issue is covered in post-op.	**ACTION:** The pre-printed orders were approved and is going forward for Board approval as moved by Dr. Johnson and seconded by Dr. Contardo.	Patricia Guerra
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Dr. Johnson moved, Dr. Contardo seconded and it was unanimously approved to go into closed session at 1:10 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:25 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No Comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:33 PM		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
July 16th, 2015

CONTACT: Sharon Schultz, CNE

Patient Care Services Policies & Procedures	Reason	Recommendations
1. Communication with the Sensory Impaired and-or Persons with Language Barriers	3 year review, practice change	Forward to BOD for approval
2. Dialysis, Acute Treatment of the Inpatient Policy	Practice change	Forward to BOD for approval
3. Hemodialysis, Care of Patient Procedure	DELETE	Forward to BOD for approval
4. Emergency Department Admission Standardized Procedure	Practice change	Forward to BOD for approval with revisions
5. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure	2 year review	Forward to BOD for approval
6. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	3 year review	Forward to BOD for approval with revisions
7. Infusion Pumps, Intravenous Therapy Policy	3 year review	Forward to BOD for approval
8. Methicillin Resistant Staphylococcus Aureas (MRSA) Screening Standardized Procedure	2 year review, practice change	Forward to BOD for approval with revisions
9. Pain Management Policy	Practice change	Forward to BOD for approval with revisions
10. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	3 year review	Forward to BOD for approval
11. Restraints Used for Non-Violent Self-Destructive Behavior Policy	3 year review, practice change	Forward to BOD for approval with revisions
12. Restraint Seclusion for Violent, Self Destructive Behavior Policy	3 year review, practice change	Forward to BOD for approval with revisions
Administrative Policies		
1. Incident Report-Quality Review Report (QRR) 396	3 year review, practice change	Pulled for further review
Unit Specific		
Neonatal Intensive Care Unit		
1. Car Seat Challenge Test	2 year review, practice change	Forward to BOD for approval with revisions
Women and Newborn Services		
1. Car Seat Challenge Test	DELETE	Forward to BOD for approval
Emergency Operations Procedures Manual (formerly Disaster Manual)		
Section 3 – Special Circumstances		
1. Code Silver Person with Weapon or Active Shooter	NEW	Forward to BOD for approval
Pharmacy		
1. Chemotherapy, Prescribing, Processing, and Preparation	3 year review, practice change	Forward to BOD for approval with revisions
2. Clinical Intervention Activity Documentation Program	3 year review, practice change	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
July 16th, 2015

CONTACT: Sharon Schultz, CNE

Pharmacy (Continued)	Reason	Recommendations
1. Clinical Protocol Drug Therapy Consults	DELETE	Forward to BOD for approval
2. Completion of Therapeutic Drug Monitoring Profiles	DELETE	Forward to BOD for approval
3. Controlled Substance	DELETE	Forward to BOD for approval
4. Controlled Substances – Pharmacy	3 year review, practice change	Forward to BOD for approval
5. Digifab Use in Digoxin Toxicity	DELETE	Forward to BOD for approval
6. Floor Stock	3 year review, practice change	Forward to BOD for approval
7. Licensure and Professional Standards	3 year review, practice change	Forward to BOD for approval
8. Medication Orders (Pharmacy)	DELETE	Forward to BOD for approval
9. Medication Preparation	3 year review, practice change	Forward to BOD for approval
10. Patient Specific Information	3 year review, practice change	Pulled for further review
11. Pharmacists Therapeutic Intervention	DELETE	Forward to BOD for approval
12. Pharmacy Range Order Policy	DELETE	Forward to BOD for approval
13. Poison Control	DELETE	Forward to BOD for approval
14. Prescribing Ordering - General Practices	DELETE	Forward to BOD for approval
15. Procurement of Medications	DELETE	Forward to BOD for approval
16. Questionable Medication Orders	DELETE	Forward to BOD for approval
17. Radioactive Medications	DELETE	Forward to BOD for approval
18. Restricted Antimicrobials	3 year review, practice change	Forward to BOD for approval
19. Self Administration of Medications by Patients and Non Staff Members	DELETE	Forward to BOD for approval
20. Succimer (Chemet) in Lead Poisoning	DELETE	Forward to BOD for approval
21. Technician Checking Technician Program	3 year review, practice change	Forward to BOD for approval
22. Therapeutic Drug Monitoring	DELETE	Forward to BOD for approval
23. Unlabeled Uses of FDA-Approved Medications	3 year review, practice change	Forward to BOD for approval
24. Unusable and Outdated Drugs	3 year review, practice change	Forward to BOD for approval
Pre-Printed Orders		
1. Inpatient Pre-Surgical AM Orders	3 year review, practice change	Forward to BOD for approval
2. Outpatient Pre and Post Operative Orders	3 year review, practice change	Forward to BOD for approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**11/88**	**SUBJECT:**	**Communication with the Sensory Impaired (Blind/Deaf)**
REVISION DATE:	**9/91, 7/94, 10/99, 6/03, 6/05, 7/07 08/08, 11/09; 11/11**	**POLICY NUMBER:**	**II.H**

Clinical Policies & Procedures Committee Approval:	**~~12/11~~05/15**
Nurse Executive Council:	**~~12/11~~05/15**
Medical Executive Committee Approval:	**~~03/12~~06/15**
Professional Affairs Committee Approval:	**~~05/12~~07/15**
Board of Directors Approval:	**05/12**

A. **DEFINITIONS**:

1. **Hearing Impaired**: A hearing impaired individual has difficulty hearing and/or discriminating oral conversation either in a face-to-face situation or over the telephone. An individual with this impairment may require a hearing aid, telephone amplifier, Telecommunication Device for the Deaf/TeleTYpewriter **(TDD/TTY)** or sign language interpreter.
2. **Visually Impaired (**visual impairment, partial sight, low vision, legally blind or totally blind): A visually impaired individual has some difficulty seeing and reading information and may require special assistance and/or supportive tools including non-visual resources.

B. **POLICY:**

1. In accordance with regulatory standards, the following provisions have been established **and will be implemented by staff caring for the patient with communication impairment**.
   a. Hearing Impaired
      i. Sign language charts are available in the Tri-City Medical Center Telephone Directory and on the intranet under "Patient Information."
      ii. Video remote services and/or TDD/TTY through hospital designated provider shall be provided for the hearing impaired and are located in the Private Branch Exchange (PBX).
         1) See instructions for Video Remote Services on the Intranet
      ~~1)~~**iii. Community resources such as sign language interpreters are available upon request**
   b. Visually Impaired
      i. Visually impaired patients shall be provided with adaptive devices, such as squeeze balls for call lights.
         1) Squeeze balls can be obtained from the Engineering Department.
      ii. All documents that patients are asked to read or sign shall be read aloud to visually impaired patients, questions shall be addressed, and patient verbalization of understanding documented.

C. **DOCUMENTATION**

1. Nursing or departmental staff shall record the patient's communication method in the medical record.

D. **FORMS/RELATED DOCUMENTS~~INTRANET REFERENCES~~**

1. Video Remote Services Instructions

E. **REFERENCES**

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
3. Joint Commission Hospital , Supporting Effective Communication, Cultural Competence, and Patient Centered Care 2011-2012

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 3/02

SUBJECT: Dialysis, Acute Treatment of the Inpatient

REVISION DATE: 10/02, 6/03, 4/06, 7/08, 5/11; 6/14

POLICY NUMBER: IV.FF

Clinical Policies & Procedures Committee Approval:	**~~06/14~~05/15**
Nursing Executive Committee Approval:	**~~06/14~~05/15**
Pharmacy & Therapeutics Committee Approval:	**05/15**
Medical Executive Committee Approval:	**~~07/14~~06/15**
Professional Affairs Committee Approval:	**~~08/14~~07/15**
Board of Directors Approval:	**08/14**

A. **POLICY:**

1. Tri-City Medical Center (TCMC) has a contractual agreement with San Diego Dialysis (**F**resenius) to perform acute hemodialysis and peritoneal dialysis for inpatients.

2. **Dialysis will be done in the patient's room.** ~~Patients shall be dialyzed on the nursing units at bedside~~.

3. **Emergency situations:**

a. **The dialysis registered nurse (RN) will implement a Rapid Response or Code Blue if necessary by dialing 66 via the phone to report a Code Blue and initiate Basic Life Support (BLS) to the dialysis patient.**

b. **In case of emergent situation, the Assistant Nurse Manager/Relief Charge RN on the unit will be notified immediately by the dialysis nurse.**

~~1.~~**c.** **The Rapid Response Team (RRT) will be contacted to provide care for the dialysis patient if the dialysis nurse becomes incapacitated until a replacement dialysis RN can be found or treatment is discontinued.**

~~2.~~**4.** TCMC's direct care responsibilities for patients undergoing dialysis treatments are as follows:

a. **Delivering ~~N~~n**ursing care normally provided to patients while not receiving dialysis, unless otherwise contraindicated during dialysis. This includes treating pain and providing immediate emergency response in the event a patient on dialysis treatment suffers a sudden change in condition.

b. **Administering medications:**

i. **The primary RN will be responsible for administering all routine intravenous (IV) medications**

ii. Review the **electronic medication administration (E**MAR) for post dialysis **IV** medications. **Post Dialysis IV medications are to be administered by the primary RN unless patient has no IV access.**

1) If no IV access, **the ~~request Fresenius~~ dialysis nurse will administer the~~to give~~** post dialysis IV medications

~~b.~~**c.** Providing the dialysis staff with equipment and supplies outlined in Dialysis Supplies and Equipment Provided by TCMC. .

~~c.~~**d.** Providing written physician orders for the necessary dialysis services and making these orders available to the dialysis staff at the time services are to be rendered.

~~d.~~**e.** Obtaining a signed consent for hemodialysis from the patient or appropriate designee prior to the first treatment.

~~e.~~**f.** Providing access for treatment. The physician who inserts a dialysis catheter is responsible for proper placement via chest x-ray that is confirmed by a radiologist.

~~3.~~**5.** Fresenius Medical direct care responsibilities for patients undergoing dialysis are as follows:

a. Providing specially trained and competent nursing staff that will perform all patient care functions directly related to the dialysis services ordered.
b. Adhering to TCMC policies and procedures, and all regulatory requirements
c. Providing those items in Dialysis Supplies and Equipment Provided by Fresenius.
d. Maintaining equipment required for dialysis treatments, including set-up, take down, and cleaning.
e. Obtaining and reviewing physician orders directly related to the dialysis services for appropriateness, and directly contacting ordering physicians for any order clarification required.
    i. Review for post dialysis medications and request all of the medications from pharmacy.
f. Administering medication and blood products that are ordered during dialysis.
~~ii.~~**g. Contacting the physician and the primary nurse for any urgent or emergent changes in the patient condition.**
h. Documenting nursing services provided during treatment per **F**resenius policy ~~**that apply to the dialysis treatment.**~~
    i. The following shall be documented in the electronic health record:~~.~~
        1) Intake/Out
        2) Vital signs
        3) Medications and blood products administered during dialysis
        4) Central line dressing change (if performed by dialysis RN)
        ~~f.~~**5) Appropriate dialysis service charges**
    ~~i. Document post dialysis vital signs in the electronic health record.~~
~~g.~~**i.** Assure~~sing~~ patient is medically stable before leaving at completion of treatment.
~~h.~~**j. Participates** ~~Will receive~~ **doin a** ~~a~~-hand-off report **with** ~~from~~ the patient's primary nurse pre **and** ~~-dialysis~~**post dialysis** treatment.

~~i.~~B. HANDOFF COMMUNICATION

1. Before the dialysis treatment starts, the primary RN ~~W~~**will provide** ~~give~~ a ~~post dialysis~~ handoff report to the **dialysis RN**~~patient's primary nurse~~ that will include but not limited to:
    a. Vital signs
    b. Weight
    c. Intake/output
    d. Most recent blood sugar as applicable
    e. Review of medication orders, including medications given
    f. Orientation, level of consciousness
    g. Dialysis access
    h. Code status
~~4.~~**2. When the patient has completed the dialysis treatment, the dialysis RN will provide hand off report to the primary RN that will include but not limited to:**
    a. How patient tolerated treatment
    b. **Intake/output including** ~~D~~**d**ialysis output
    c. ~~Current v~~**V**ital signs
    d. Medications given **during dialysis**~~and/or~~
    ~~d.~~**e. B**~~b~~lood products **administered**
    ~~e.~~**f. Post** ~~D~~**d**ialysis **access care (i.e. bleeding) and status of dressing** ~~catheter assessment~~
    ~~f.~~**g. Review of post dialysis medication orders** ~~Any medications not given on dialysis that need to be administered by the primary care nurse (i.e. IV antibiotics).~~

~~3.~~C. FORMS/RELATED DOCUMENT ~~(LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS/RELATED DOCUMENTS FOLDER):~~

1. Dialysis Supplies and Equipment Provided by TCMC
2. Dialysis Supplies and Equipment Provided by Fresenius

Tri-City Medical Center	Distributio

DELETE – incorporated into PCS Dialysis, Acute Treatment of the Patient policy

PROCEDURE:	**HEMODIALYSIS, CARE OF PATIENT**
Purpose:	To establish a procedure for communication and care of patients receiving inpatient hemodialysis.
Equipment:	Cerner –Chart Summary Screen

A. ~~**PROCEDURE:**~~

1. ~~The hemodialysis Registered Nurse (RN) will call **or have a face to face hand-off report with** the hemodialysis patient's primary RN for a hand-off report before patient is transported to room for dialyz**ed.**sis.~~
2. ~~RN will provide the following information during hand-off report to the hemodialysis RN:~~
   - i. ~~Patient's name and medical record number~~
   - ii. ~~Current vital signs, weight, intake/output, and most recent blood sugar if applicable.~~
   - iii. ~~Pain history, medication they are currently taking for pain and last dose.~~
   - iv. ~~Medications given last 12 hours~~
   - v. ~~Medications to be given during post-dialysis~~
   - vi. ~~Fall risk score~~
   - vii. ~~Activity~~
   - viii. ~~Level of consciousness~~
   - ix. ~~Wounds and drains~~
   - x. ~~Any abnormal assessment findings~~
   - xi. ~~Type of IV access~~
   - xii. ~~Current Graph, Vas Cath, Perma Cath or fistula assessment~~
   - xiii. ~~Code status~~

   ~~**Hemodialysis will be done at bedside in the patient's room**~~
3. ~~The patient will then be transported to room for dialysis after the hand-off report is completed.~~
4. ~~The patient will be transported to room for dialysis with their chart, a verified patient identification armband, allergy armband.~~
5. ~~Hemodialysis orders will be carried out by the hemodialysis RN.~~

   ~~**The hemodialysis RN will be responsible for administering medications and blood products that are ordered during dialysis.**~~

   ~~T**The primary RN will be responsible for administering routine medications and care.**~~
6. ~~The Hemodialysis nurse will implement a Rapid Response or Code Blue if necessary by dialing 66 via the phone to report a Code Blue and initiating Basic Life Support (BLS) to the hemodialysis patient.~~
7. ~~In case of emergent situation, the Assistant Nurse Manager/Relief Charge RN on 4 Pavilion**the unit** will be notified immediately **by the dialysis nurse**.~~
8. ~~The hemodialysis RN will be responsible for contacting the physician and the primary RN of any urgent or emergent changes in patient's condition.~~
9. ~~When the patient has completed the hemodialysis treatment, the hemodialysis RN will **give hand-off** call report to the primary care nurse before the hemodialysis patient is transported back to the unit.~~
   - a. ~~Information during hand-off report to the primary RN shall include:~~
     - i. ~~Patients name and medical record number~~
     - ii. ~~Patient tolerance of hemodialysis~~
     - iii. ~~Current vital signs, intake/output, dialysis output, most recent blood glucose if applicable and any blood products administered.~~
     - iv. ~~Level of consciousness~~
     - v. ~~Any abnormal assessment findings~~
     - ~~**Medications given during dialysis**~~

Department Review	Clinical Policies & Procedures	Pharmacy & Therapeutics Committee	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/06; 6/09	07/11, 05/15	05/15	08/11, 05/15	10/11,06/15	11/11, 07/15	11/11

~~Current Graph, Vas Cath, Perma Cath or fistula assessment~~

10. ~~When hemodialysis is done in the room:~~
    a. ~~Before and after hemodialysis in the room, hand-off report shall be given.~~
    b. ~~The primary RN will be responsible for administering routine dialysis medications and care.~~
    c. ~~The hemodialysis RN will be responsible for administering routine medications and blood products ordered during dialysis, drawing labs as requested by the physician, and informing the primary RN if there is an urgent or emergent situation.~~
11. ~~Hemodialysis RN shall document the following in Cerner:~~
    a. ~~Intake/Output~~
    b. ~~Medications and blood products that were administered during dialysis.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: EMERGENCY DEPARTMENT ~~ADMISSION~~

II. **POLICY:**

A. Function: To define appropriate utilization of specific orders and order sets, otherwise referred to as standardized procedures.

B. Circumstances:

1. Setting: Tri-City Medical Center, Emergency Department (ED) ~~Patient Triage~~
2. Supervision: ~~None required~~ **~~Registered Nurses will be immediately supervised by a physician in the Emergency Department at all times.~~ An Emergency Services Physician will be available for consultation. Registered Nurses will immediately contact the physician for any patient who is critical in nature or unstable. Physician contact will not be delayed in order to initiate or complete Standardized Procedures.**
3. Patient contraindications: None

C. Documentation:

1. The Registered Nurses (RN) will ~~enter~~ document all interventions performed ~~Standardized Procedures~~ into the electronic health record (EHR).~~as "Standardized Procedures."~~

2. The RN will enter all orders performed per the standardized procedure in the EHR.

~~The Physician identified when entering the order should read "EDPhysicianNot Seen By."~~

~~C. Expected outcomes of triage are to:~~

~~a. Assess to establish patient care priority according to acuity and resources required. Patients may be re-categorized at any time.~~

~~2. POrder medications, initial labs, and x-rays per the following standardized procedure or consult the ED physician for guidance.~~

~~3. Provide brief selected first aid treatments.~~

~~4. Identify patient or family health learning needs.~~

~~5. Promote community rapport through demonstration of concern for ED patient problems.~~

III. **~~P~~PROCEDURE:**

A. Abdominal Pain ~~Female~~ between the ages of 10 – **25** ~~49~~:

1. ~~If a female~~ **In** patient**s who** presents ~~to~~ **the ED**~~triage~~ with abdominal pain, the RN shall order the following:

a. **Labs:**

i. CBCD
ii. Metabolic Panel, Comprehensive
iii. Jic Blue
iv. **Serum HCG in females**~~Lipase level~~

b. **Nurse Orders:**

i. Routine urinalysis **with reflex culture**
~~ii. Urine culture (if indicated)~~
~~iii. Urine HCG~~

Revision Dates	Clinical Policies & Procedures	Nursing Executive Committee	Department of Emergency Medicine	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/04, 3/06, 8/08, ~~8/08,~~ 7/09, 6/11, 6/14	01/11, 11/13; 10/14; 01/15	01/11; 11/13; 10/14; 02/15	6/11; 12/14	06/11; 11/13; 01/15	06/11; 2/14; 06/15	06/11; 2/14~~7~~; 06/15	06/15	06/11; 2/14

~~iv. Consult with physician regarding CT scan~~

c. ~~Radiology:~~ Medications:

~~c.~~i. Ondansetron (Zofran) 8 mg oral disintegrating tablet (ODT) ~~x~~ times one (1), prn for nausea in patients 16 years of age and older.

B. Abdominal Pain, ~~Male between the~~ ages **26 and older** ~~of 18 – 49~~:

1. ~~If a male p~~ **In** patient**s who** presents to ~~triage~~ **the Emergency Department** with abdominal pain, the RN shall order the following:

a. **Labs:**

i. CBCD

ii. Metabolic Panel, Comprehensive

iii. Jic Blue

iv. ~~Lipase level~~**Serum HCG in females aged 26 to 55**

b. **Nurse Orders:**

i. Routine urinalysis **with reflex culture**

~~ii. Urine culture (if indicated)~~

~~iii. Consult with physician regarding CT scan~~

c. ~~Radiology:~~ Medications:

~~c.~~i. Ondansetron (Zofran) 8mg ODT ~~x~~times one (1), PRN for nausea, in patients 16 years or older.

~~i. If physician approves CT scan order, RN shall order CT Abdomen and Pelvis with or without Contrast~~

d. Additional orders if patient presents with upper abdominal pain (above umbilicus or abdominal pain of unknown location) to rule out cardiac conditions:

~~C. Abdominal Pain for Patients 50 years of age and older:~~

~~1. If a patient presents to triage with abdominal pain, the RN shall order the following:~~

~~a.~~i. Cardiology:

~~i.~~1. EKG **STAT**

~~1.~~1) Print old EKG if available

2) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to ED physician ~~for interpretation~~ to rule out ST-elevation Myocardial Infarction (STEMI)

ii. **Labs:**

1. Creatine Kinase (CPK)
2. CK, Mb Fraction (CKMB) **IF**
3. Cardiac Troponin (Troponin I)
4. Lipase level

~~5. CBCD~~

~~6. Metabolic Panel, Comprehensive~~

~~7. Jic Blue~~

~~b. Nurse Orders:~~

~~i. **Routine** urinalysis~~

~~ii. Urine culture~~

~~iii. Consult with physician regarding CT scan~~

~~c. Radiology:~~

~~i. If physician approves CT scan order, RN shall order CT Abdomen and Pelvis with or without Contrast~~

~~ii.~~

~~D.~~**C.** Asthma with Wheezing:

1. ~~If~~ **In**-patient**s who** presents to **ED** ~~triage~~ with wheezing and a stated history of asthma, the RN shall order the following:

a. **Nursing Orders:**
   i. Pulse oximetry monitoring
b. ~~**Respiratory:**~~ **Medications:**
   i. **Albuterol 5 mg nebulized ~~x~~times one (1) with Ipratropium 0.5 mg nebulized ~~x~~times one (1) per ~~r~~Respiratory ~~t~~Therapy, in patients who are greater than 11 years of age.** ~~Mini-nebulizer treatment~~
      ~~1. If patient is 2 to 11 years of age, administer 2.5 mg Albuterol (Proventil) and 0.5 mg Ipratropium Bromide (Atrovent)~~
   ~~2. If patient is greater than 11 years of age, administer 5 mg albuterol and 0.5 mg ipratropium~~
   ~~If physician approves CT scan order, RN shall order CT Abdomen and Pelvis with or without Contrast~~

~~E.~~**D.** Chest ~~Pain~~ **Discomfort** in Patients **over** 30 years of age:

1. ~~If~~ **In** patient**s who** presents to **the ED**~~triage~~ with chest pain, **pressure, squeezing,** shortness of breath, ~~chest pressure,~~ pain or discomfort in other parts of the ~~upper~~ body including one or both arms **or shoulders, upper** back, neck, jaw, abdomen, ~~etc.,~~**or female, elderly or diabetic patients with atypical symptom suspicious for acute coronary syndrome (ACS) such as diaphoresis, nausea, dizziness, altered level of consciousness** the Registered Nurse (RN) shall order the following:
   a. **Cardiology:**
      i. EKG STAT
         a) Print old EKG if available
         ~~a)~~**b) STAT ED EKG's will be completed with the goal of 10 minutes of being ordered and delivered directly to an ED physician ~~for interpretation.~~ to rule out STEMI.**
   b. **Labs:**
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Creatine Kinase (CPK)
      iv. CK, Mb Fraction (CKMB) **if CPK above normal**
      v. Cardiac Troponin (Troponin I)
   c. **Nurse Orders:**
      i. Bring patient to ~~room 30 or~~ first available bed
      ii. Initiate at least one peripheral intravenous (IV) saline lock
      iii. Initiate cardiac monitor
      iv. Initiate oxygen 2 liters per minute (LPM) per nasal cannula (NC) to maintain oxygen saturation by pulse oximetry (SPO2) greater than 92%
   d. Medications:
      i. Aspirin 325 mg one (1) tablet by mouth (PO) chewed times one (1) if not already administered
      ~~i.~~**ii. Nitroglycerin (NTG) 0.4 mg sublingually, every five (5) minutes times three (3) doses for ongoing chest pain**
   ~~d.~~**e. Radiology:**
      i. X-Ray Chest 2 View
         1. **If patient is female and under 55~~0~~, shield pelvis**

E. Dysuria:

1. **In patients who present to the ED with dysuria, hematuria, urgency, or frequency, the RN ~~may~~shall order:**
   a. Nurse Orders:

i. Routine urinalysis with reflex culture
ii. Urine HCG for females age 10-55

~~F.~~

~~G.~~**F.** Extremity Trauma:

1. Notify physician STAT for open fractures, dislocations, or neurological or vascular compromise.
2. Consult physician for x-ray orders for back, skull, facial bones, chest, pelvis, hips, and ribs.
3. **In** ~~f~~patient**s who** present ~~s~~to **ED**~~triage~~ with **injuries** ~~extremity pain and~~**that are suspicious for** ~~suspected possible~~fracture, the RN shall order the following: ~~x-rays; as appropriate to pain location.~~

a. Medications:

i. Acetaminophen

1. For ages 3 months-11 years, acetaminophen 105mg/kg PO or PR times one (1), round to nearest 5mg

a. Maximum 2600mg/day
b. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.

2. For 12 years and older, acetaminophen 650mg PO or PR times one (1)

a. Maximum 3000mg/day
b. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.

~~3.~~**b. Radiology:**

~~a.~~**i.** Acromioclavicular Joints
~~b.~~**ii.** Ankle complete 4 views left
~~c.~~**iii.** Ankle complete 4 views right
~~d.~~**iv.** Heel left OS Calcis
~~e.~~**v.** Heel right OS Calcis
~~f.~~**vi.** Clavicle left
vii. Clavicle right
viii. Elbow left
~~g.~~**ix. Elbow right**
~~h.~~**x.** Femur left
xi. Femur right
xii. Finger left
~~i.~~**xiii. Finger right**
~~j.~~**xiv.** Foot 4 views left
~~k.~~**xv.** Foot 4 views right
~~l.~~**xvi.** Forearm left
~~m.~~**xvii.** Forearm right
~~n.~~**xviii.** Hand 4 views left
xix. Hand 4 views right
xx. Hip Left, with AP Pelvis
~~o.~~**xxi. Hip Right with AP Pelvis**
~~p.~~**xxii.** Humerus left
xxiii. Humerus right
xxiv. Knee left
~~q.~~**xxv. Knee right**
~~r.~~**xxvi.** Shoulder left
~~s.~~**xxvii.** Shoulder right
~~t.~~**xxviii.** Tibia/Fibula left

~~u.~~**xxix.** Tibia/Fibula right
~~v.~~**xxx.** Wrist 4 views left
~~w.~~**xxxi.** Wrist 4 views right
xxxii. X-ray extremity wound site if suspect foreign body

~~x.~~

~~H.~~**G.** Fever in children **under 3 months of age**:

1. ~~If~~**In** patient**s who are under 3 months of age and who** presents to **ED**~~triage~~ with **rectal** temperature of **38°C (100.4°F)** or greater**, assign an emergency severity index (ESI) level 2 and arrange for immediate placement in the treatment area. T**~~t~~he RN shall order the following:
   a. **Labs:**
      i. CBC**D** ~~M STAT~~
      ii. Metabolic Panel, Basic ~~STAT~~
      iii. C-Reactive Protein (CRP) ~~(Not High Sensitivity))~~
      iv. Blood Culture ~~STAT~~
   b. **Nurse Orders:** ~~**all orders are STAT**~~
      i. Routine urinalysis, catheter specimen
      ii. Urine culture ~~if indicated~~
      ~~iii.~~ Pulse oximetry monitoring
      ~~iv.~~**iii.** ~~Bring patient to bed immediately~~
      ~~v.~~**iv. Initiate intravenous (IV) saline lock**~~After patient is placed in bed, the RN shall:~~
         ~~1. Start saline lock~~
         ~~2. Set up LP Pediatric Tray with extra 22-gauge pediatric spinal needle~~
   c. **Medications:**
      i. Acetaminophen 10~~5~~ mg/kg PO or PR times one (1)
         1. Maximum 2600mg/day
         2. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
   ~~c.~~**d. Radiology:**
      i. X-Ray: Chest 2 View PA and LAT

~~i.~~

H. Fever in ~~children~~ **patients older than >3 months of age**:

1. In patients who present to the ED with fever, the RN ~~may~~shall order:
   a. Medications:
      i. Acetaminophen
         1. For ages 3 months - 11 years, acetaminophen 10~~5~~mg/kg PO or PR times one (1), round to nearest 5mg
            a. Maximum 2600mg/day
            b. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
         2. For 12 years and older, acetaminophen 325mg PO or PR times one (1)
            a. Maximum 3000mg/day
            b. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
      ii. Ibuprofen
         1. For ages 6 months to 11 years, ibuprofen 10mg/kg PO times one (1), round to nearest 5mg

a. Maximum 40mg/kg/day
b. Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

2. For 12 years and older, ibuprofen 400mg PO times one (1)
a. Maximum 3200mg/day
~~d.~~b. Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

I. Generalized Weakness, **Syncope, Dizziness or Altered Mental Status**

1. ~~If~~ **In** patient**s who** presents to ~~triage~~ **ED** with generalized weakness, **syncope, or dizziness,** the RN shall order the following:

a. **Cardiology:**
i. **STAT** EKG
1. Print old EKG if available
~~1.~~2. STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to an ED physician ~~for interpretation.~~ to rule out STEMI.

b. **Labs:**
i. CBCD
ii. Metabolic Panel, Comprehensive
iii. Creatine Kinase (CPK)
iv. CK, Mb Fraction (CKMB) **IF**
v. Cardiac **T**roponin (Troponin I)

c. **Nurse Orders:**
i. Routine urinalysis, clean catch
ii. Urine culture, clean catch
iii. Urine HCG if ~~patient is~~ female and 10 – 5~~0~~ years of age

d. **Radiology:**
i. Chest X-ray 2 View PA and LAT
1. If patient female and under 50 years of age, shield pelvis

~~J. Syncope:~~

~~1. If patient presents to triage with syncopal episodes, the RN shall order the following:~~

~~a. **Cardiology:**~~
~~i. EKG~~
~~1. Print old EKG if available~~
~~b. **Labs:**~~
~~i. CBCD~~
~~ii. Metabolic Panel, Comprehensive~~
~~iii. Creatine Kinase (CPK)~~
~~iv. CK, Mb Fraction (CKMB)~~
~~v. Cardiac Troponin (Troponin I)~~
~~c. **Nurse Orders:**~~
~~i. Routine urinalysis, clean catch~~
~~ii. Urine culture if indicated, clean catch~~
~~iii. Urine toxicology screen (clean catch) per physician's request~~
~~iv. Urine HCG if patient is female and 10 – 50 years of age~~
~~d. **Radiology:**~~
~~i. Chest X-ray 2 View PA and LAT~~
~~1.~~**ii.** ~~If patient female and under 50 years of age, shield pelvis~~

~~K.~~**J.** **Gastro Intestinal (GI)** Bleed

~~1. If patient has excessive bleeding or systolic blood pressure (SBP) less than 100 mmHg, notify the Assistant Nurse Manager (ANM)/Relief Charge Nurse immediately for bed placement~~

~~2.~~**1.** In~~f~~ patient**s who** presents to **ED** ~~triage with minimal bleeding,~~**with the complaint of blood in the stool, vomiting of blood or coffee ground emesis, and a** ~~with~~ **systolic blood pressure** (SBP) ~~greater~~ **less than or equal to 90** ~~than 100~~ mmHg, the RN shall order the following:

a. **Nurse Orders:**
   i. **Initiate two 16 ~~guage~~ gauge (if possible) peripheral IVs**

b. Medications:
   ~~ii.~~**i. Administer 500 ml 0.9 NaCl IV fluid bolus times one (1), infuse over 30 minutes**
   ~~iii. Routine urinalysis, clean catch~~
   ~~iv. Urine culture, clean catch~~
   ~~b. Urine HCG if patient is female and 10 – 50 years of age~~

c. **Labs:**
   ~~d.~~**i. Type and Screen**
   ii. Check Bedside glucose
   ~~i.~~**iii.** CBCD
   ~~ii.~~**iv.** Metabolic Panel, Comprehensive
   ~~iii. Creatine Kinase (CPK)~~
   ~~iv. CK, Mb Fraction (CKMB)~~
   ~~v. Cardiac Troponin (Troponin I)~~
   ~~vi. Lipase Level~~
   ~~vii. Protime/INR Battery~~
   ~~viii. Partial Thromboplastin Time~~
   ~~ix. Jic Blood Bank~~
   ~~e. **Radiology:**~~

~~i. Ches~~**t X-ray 2** ~~View PA and LAT~~

~~If patient female and under 50 years of age, shield pelvis~~

~~1.~~

~~L.~~**K.** Psychiatric Evaluation

1. **Patients who present to the ED with suicidal ideation, hallucinations, delusions, or who are an immediate safety risk to self or others ~~at risk for safety~~ will be assigned an Emergency Severity Index (ESI) Level 2 and moved to the treatment area as soon as possible.** ~~If RN is concerned for patient's safety or other's safety, notify ANM/Relief Charge RN immediately for bed placement.~~**If immediate bed placement is not possible for psychiatric patients at risk, security should be notitified for direct observation while bed placement is arranged.**
2. ~~If~~ **In** patient**s who present to the ED with the above complaints t**~~presents to triage as a possible danger to self, others, or is gravely disabled, t~~he RN shall order the following:

a. **Labs:**
   i. CBCD
   ii. Metabolic Panel, Comprehensive
   iii. Ethanol, Serum (Blood Alcohol Level)
   iv. Urine toxicology screen
   v. Cannabinoid level
   vi. TSH level
   ~~iii.~~**vii. Serum HCG if female age 10 to 55**

b. **Nurse Orders:**
   i. Urinalysis, routine **with reflex culture** ~~(clean catch)~~
   ~~ii. Urine culture (clean catch)~~
   ~~iii. Urine toxicology screen (clean catch)~~
   ~~iv. Abdominal/pelvic ultrasound, if approved by physician~~
   ~~v. Urine HCG for female patients between the ages 10 – 50~~

~~M.~~**L.** Vaginal ~~b~~**B**leeding, **Know P**~~p~~regnancy~~t~~:

1. **In**~~f~~ patient**s who** presents to **the ED** ~~triage~~ with vaginal bleeding, and **who are pregnant**~~states she is pregnant and is 18 years of age or older,~~ the RN shall order the following:
   a. **Labs:**
      i. CBCD
      ii. ABORh Type
      iii. Beta HCG, Quantitative
   b. **Nurse Orders:**
      ~~i. Notify physician immediately if patient's heart rate is greater than 120 bpm or SBP is less than 90 mmHg~~
      i. ~~After patient is placed in bed, the RN shall:~~ **If heart rate is >greater than 120 BPM or the systolic blood pressure is <less than 90 mmHg:**
         ~~ii.~~**1. Immediately notify physician of patient's condition**
         2. Initiate two 16 gauge (if possible) peripheral IV's
         ~~1.~~**3. Set up for** ~~P~~**p**elvic ~~setup~~ **exam** and notify physician
         ~~2.~~**4.** Routine urinalysis **with reflux culture**, catheter specimen
         ~~Urine culture if indicated, catheter specimen~~
   c. Medications:
      i. **Administer 500 ml 0.9 NaCl IV fluid bolus times one, infuse over 30 minutes**

M. Vomiting, Diarrhea, Dehydration:

1. ~~If~~ **In** patient**s who** presents to **the ED**~~triage~~ with vomiting**,** ~~and~~ diarrhea **and or dehydration**~~, showing signs of dehydration and is age 18 or older,~~ the RN shall order the following:
   c. Nurse orders:
      i. Initiate peripheral IV for severe vomiting
   d. Medications:
      ~~2.~~**i. Adults (16 years of age and older):**
         ~~3.~~**1. Ondansetron 8 mg ODT** ~~x 1~~**times one (1)** ~~**in patients 16 years of age and older**~~
         2. Ondansetron 4 mg IVP ~~x1~~**times one (1)** ~~**in patients 16 years of age and older**~~ **for severe vomiting.**
      ii. Pediatrics (0 to 15 years of age):
         1. Ondansetron 2 mg ODT times one (1) in patients less than 15 kg
         2. Ondansetron 4 mg ODT times one (1) in patients greater than 15 kg

~~a. **Labs:**~~
~~i. Complete Blood Count (CBC)~~
~~ii. Metabolic Panel, Comprehensive~~
~~b. **Nurse Orders:**~~
~~i. Routine urinalysis, clean catch~~
~~ii. Urine culture if indicated, clean catch~~
~~iii. Urine HCG if patient is female and 10 – 50 years of age~~
~~iv. Administer Ondansetron (Zofran ODT) 8 mg PO, disintegrating tablet X 1~~
~~N. Respiratory Symptoms "Flu" for Patients **over** 50 years of age:~~
~~1. If patient presents to triage with flu-like symptoms, the RN shall order the following:~~
~~a. **Cardiology:**~~
~~i. EKG~~
~~1. Print old EKG if available~~

~~b. **Labs:**~~
~~i. CBCD~~
~~ii. Metabolic Panel, Comprehensive~~
~~iii. Creatine Kinase (CPK)~~
~~iv. CK, Mb Fraction (CKMB)~~
~~v. Cardiac Troponin (Troponin I)~~
~~vi. Jic Blue~~
~~c. **Nurse Orders:**~~
~~i. Perform an influenza swab then place mask on patient~~
~~d. **Radiology:**~~
~~i. X-Ray: Chest 2 View PA and LAT, if cough present~~
~~O. Palpitations:~~
~~1. If patient presents to triage with palpitations, the RN shall order the following:~~
~~a. **Cardiology:**~~
~~i. EKG~~
~~1. Print old EKG if available~~
~~b. **Labs:**~~
~~i. CBC~~
~~ii. Metabolic Panel, Comprehensive~~
~~iii. Creatine Phosphokinase (CPK)~~
~~iv. CK, Mb Fraction (CKMB)~~
~~v. Cardiac Troponin (Troponin I)~~
~~vi. Jic Blue~~
~~vii. Protime/INR Battery (PT) if patient is on Coumadin~~
~~viii. Digoxin level if patient is on Digoxin or Lanoxin~~
~~P. Cough or Chronically Ill Patients **over** 50 years of age:~~
~~1. If patient presents to triage with cough or chronic illness, the RN shall order the following:~~
~~a. **Cardiology:**~~
~~i. EKG~~
~~1. Print old EKG if available~~
~~b. **Labs:**~~
~~i. CBCD~~
~~ii. Metabolic Panel, Comprehensive~~
~~iii. Blood Cultures X 2~~
~~iv. B Type Natriuretic Peptide (BNP)~~
~~c. **Nurse Orders:**~~
~~i. Place mask on patient~~
~~ii. Pulse oximetry monitoring~~
~~d. **Radiology:**~~
~~i. X-Ray: Chest 2 View PA and LAT, if cough present~~
~~Q. Shortness of Breath or Chronically Ill Patients **over** 50 years of age:~~
~~1. If patient presents to triage with cough or shortness of breath, the RN shall order the following:~~
~~a. **Nurse Orders:**~~
~~i. Place mask on patient~~
~~b. **Radiology:**~~
~~i. X-Ray: Chest 2 View PA and LAT, if cough present~~
~~ii. If patient is female, shield pelvis~~
~~R. Cough or Shortness of Breath in Patients **under** 50 years of age:~~
~~1. If patient presents to triage with cough or shortness of breath, the RN shall order the following:~~
~~a. **Nurse Orders:**~~
~~i. Place mask on patient~~
~~b. **Radiology:**~~
~~i. X-Ray: Chest 2 View PA and LAT, if cough present~~
~~1. If patient is female, shield pelvis~~

~~S. Seizures, new onset, adult age 18 or over:~~
~~1. If a patient presents to triage with seizures, the RN shall order the following:~~
~~a. **Labs:**~~
~~i. CBCD~~
~~ii. Metabolic Panel, Comprehensive~~
~~b. **Nurse Orders:**~~
~~i. Urinalysis, routine~~
~~ii. Urine culture~~
~~iii. Urine HCG for female patients between the ages 10 – 50~~
~~iv. Urine toxicology screen~~
~~v. Consult with physician regarding CT scan~~
~~c. **Radiology:**~~
~~i. If physician approves CT scan order, RN shall order CT Head without contrast~~
~~T. Seizures, recurrent 18 years or older:~~
~~1. If patient presents to triage with recurrent seizures, the RN shall order the following:~~
~~a. **Labs:**~~
~~i. Phenytoin level if patient is on Dilantin~~
~~ii. Valproic Acid level if patient is on Depakene,Depakote~~
~~iii. Phenobarbital level if patient is on Phenobarbital~~
~~b. **Nurse Orders:**~~
~~i. Consult with physician regarding CT scan~~
~~c. **Radiology:**~~
~~i. If physician approves CT scan order, RN shall order CT Head without contrast~~
~~ii.~~

~~U. Urinary Tract Infection~~
~~1. If patient presents to triage with urinary symptoms, the RN shall order the following:~~
~~a. **Labs: If patient is diabetic, immunocompromised, pregnant, or has a fever, order the following labs:**~~
~~i. CBCD~~
~~ii. Metabolic Panel, Comprehensive~~
~~iii. Blood Culture X 2~~
~~b. **Nurse Orders:**~~
~~i. Routine urinalysis, clean catch~~
~~ii. Urine culture if indicated, clean catch~~
~~iii. Urine HCG if patient is female and 10 – 50 years of age~~
~~1.~~
~~V. Neck Pain, Trauma:~~
~~1. If patient presents to triage with neck pain (traumatic) and is age 18 or older, the RN shall order the following:~~
~~a. **Nursing Orders:**~~
~~i. Apply cervical collar and take patient to first available treatment room STAT~~
~~b. **Radiology:**~~
~~i. Cervical spine 5 view~~

IV. **REQUIREMENTS FOR RN ~~AT TRIAGE~~:**
A. Excellent customer service communication
B. Education: Successful completion of ~~triage training~~**Standardized Procedure training**
C. Initial Evaluation: Demonstrated competency
D. Ongoing Evaluation: Annual skills lab.

V. **DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:**
A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration. **New standardized procedures or additions to existing**

standardized procedures will be approved by the Department of Emergency Medicine, Pharmacy and Therapeutics (if medications are involved) and the TCMC Board of Directors.

B. Review: Every two (2) years

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

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Emergency Department ~~Patient Triage~~ Standardized Procedure.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: HIV SCREENING, IDENTIFICATION/TREATMENT FOR THE PREVENTION OF PERINATAL TRANSMISSION

I. **POLICY:**

A. Function:

1. To provide guidelines for the RN to identify and provide treatment for obstetric HIV infected patients admitted to Tri-City Medical Center.
2. To identify pregnant patients with positive HIV results and reduce the risk of maternal to child transmission to the newborn.
   a. Allows intrapartum treatment for pregnant patient and fetus.
   b. Allows ongoing treatment for the pregnant patient and exposed newborn during the postpartum period.
3. To identify community resources for pregnant patients who are HIV positive
   a. University of California San Diego (UCSD) Mother and Adolescent HIV Program Hotline: (619)-543-8089.
   b. National Prenatal HIV Consultation and Referral Service: (888-448-8765)
4. To comply with Health codes as outlined in State and Federal laws – January 2008
   a. The state of California requires that all pregnant women are offered HIV screening throughout the pregnancy and at the time of hospital admission

B. Circumstances for Screening

1. Setting: Tri-City Medical Center
2. Supervision: None
3. Exclusions: Emergency Department (ED)

II. **PROCEDURE FOR INPATIENT AREAS, OTHER THAN WOMEN AND CHILDREN'S SERVICES (WCS), WHO ARE TREATING PREGNANT PATIENTS:**

A. During the patient history, data collection the RN shall complete an HIV risk screening to determine if the patient should be offered HIV testing

1. Each pregnant patient shall receive information about the importance of having an HIV test and documentation of providing this information is noted in the medical record.
2. If patient declines, the refusal shall be documented in the medical record.
3. If patient agrees to HIV testing.

B. Documentation of the pregnant patient's "acceptance of HIV testing" will automatically generate an order in the electronic medical record for the rapid HIV test lab draw.
   a. Expect results from the chemistry lab (ext 7909) within two hours once test is drawn.

C. The admitting physician will review the results and discuss the findings and antiretroviral prophylaxis with the patient in a confidential manner as indicated.

1. The admitting physician shall refer the patient with positive results to her obstetrician and/or the maternal child adolescent HIV program as soon as possible to review therapy, method of delivery, infant care, and follow-up.

III. **PROCEDURE FOR LABOR AND DELIVERY (WCS) ONLY:**

A. During the patient history/prenatal lab data collection, RN shall:

1. Perform careful screening of the patient's prenatal care or lack of prenatal care

~~Department Review~~	Clinical Policies & Procedures	Nursing Executive Council	Infection Control Committee	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
~~12/09; 8/12~~	8/12; 1/15	8/12; 02/15	03/15	9/12; 04/15	11/12, 05/15	11/12; 06/15	07/15	12/12

2. Review the patient's prenatal form for results of the prenatal HIV test. If documented test results are negative or are positive with the woman being currently treated, document results in the medical record.
   a. Refer to the WCS Procedure: "HIV Intrapartum Treatment for the Prevention of Perinatal Transmission" for patients in labor with positive results.
3. If no test results are available:
   a. Contact the provider's office and obtain the HIV test results if the prenatal indicates the test was done, but results not on the chart.
   b. Assess patient's risk factors and offer HIV testing for the following indications:
      i. Pregnant patients who have unknown HIV results
      ii. Pregnant patients who declined HIV testing in a prenatal setting, and have risk factors associated HIV exposure
      iii. Pregnant patients who are at high risk for becoming infected and have negative HIV results in the clinic setting may be offered a second HIV test in the third 3rd trimester
   c. For patient's meeting the indications listed ~~in 3.b.i-iii~~ for the Rapid HIV screen discuss the following in a confidential setting:
      i. **T**he purpose and rationale for the test
      ii. The risk and benefits of the test
      iii. Her ability to decline the test
4. Provide the patient with a copy of the Perinatal HIV Testing Information Form provided by the California Department of Health Services and the Office of AIDS.
5. Obtain consent. Only verbal consent is required for running the test.
6. Document any refusal of the HIV test in the medical record and note the reason why if possible.
7. After obtaining verbal consent for the HIV test, draw the tubes of blood (small red and purple top tubes) for prenatal labs (RN or lab)
   a. An order shall be generated as a task for the L&D RN
   b. A rapid HIV test shall be run STAT by the chemistry lab when labeled tubes are received and accompanied with the completed requisition
   c. Results will be called to the attending provider by the chemistry lab. Expect the results in about 2 hours (Chemistry lab, ext. 7909).
8. The attending provider will provide test results to the patient. **T**he lab will automatically run a confirmatory HIV test with results available with 7-10 days.
   a. If the result is negative, no further treatment is necessary.
   b. If the result is positive and the woman is not in labor:
      i. Physician will review treatment options, and discuss antiretroviral prophylaxis with the mother in a confidential manner.
      ii. **T**he patient will be referred to the UCSD maternal child adolescent HIV program as soon as possible to review therapy/method of delivery, infant care, and follow-up.
   c. If the results are positive and the woman is in labor, obtain order for antiretroviral therapy
      i. Refer to WCS Procedure: "HIV Intrapartum Treatment for the Prevention of Perinatal **T**ransmission", and PPO: "HIV Intrapartum **T**reatment"
9. Contact the Social Work department and submit a consult order for crisis intervention or postpartum counseling using the key words "Rapid **T**est Response." This wording alerts the Social Work staff that the patient is a newly screened HIV patient who may need referral to the appropriate community resources, i.e., WE CARE, County Social Services, etc.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annual Skills Lab

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

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

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

A. All healthcare providers who have successfully completed the requirements as outlined above are authorized to direct and perform HIV Identification and Screening, Prevention of Perinatal Transmission Standardized Procedure.

VII. **REFERENCES:**

A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. ~~2007~~**2012**. *Guidelines for Perinatal Care Sixth Edition.* Washington, DC
B. AAP Policy Statement, Committee on Pediatric AIDS 120(6) e1547. *Diagnosis of HIV-1* Infection in children younger than 18 months in the United States. Washington, DC
C. 682 Assembly Bill –CHAPTERED
D. ACOG Committee Opinion # 418 (9/08), Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations. November, 2004
E. ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007
F. California Law: Assembly Bill No. 1676
G. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit)
H. Pickering LK, ed. *2009 Red Book: Report of the Committee on Infectious Diseases.* 28th ed. Elk Grove Village, IL: American Academy of Pediatrics.
I. Public Health Service Task Force. Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1-Transmission in the United States, April 29, 2009. http://aidsinfo.nih.gov/guidelines/perinatal\perinatal (Updated yearly.)
J. Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports, September 22, 2006/55 (RR14); 1-17.Revised CDPH Perinatal Policy (2008)
K. National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765
L. UCSD Medical Center, Woman's and Infant's Department Policy/Procedure: "HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION" (8/15/09).
M. ACOG Committee Opinion #595, Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus. May 2014.
N. ACOG Committee Opinion # 596, Routine Human Immodeficiency Virus Screening. May 2014.
O. Simpson, K. R., & Creehan, P.A. Perinatal Nursing 4th edition 2014, pp. 679-680 Association of Women's Health Obstetric and Neonatal Nurses.

Tri-City Medical Center	Distribution:	Patient Care Services
PROCEDURE:	**INFUSION PUMP – SYRINGE OR PATIENT CONTROLLED ANALGESIC (PCA) MODULE INFUSION SYSTEM WITH GUARDRAILS**	
Purpose:	To regulate intravenous infusion using an electronic control device.	
Supportive Data:	The Alaris Intravenous Infusion Pump with Guardrails System provides medication error prevention software to protect patients at the point of infusion delivery.	
Equipment:	1. Alaris administration set 2. Primary IV solution 3. Pump programmer point of care (POC) 4. Pump Syringe Module or Patient Controlled Analgesic (PCA) Module	

A. **PROCEDURE:**

1. **Syringe Module**
   - a. Prior to the start of an infusion program, confirm syringe type and size. The system will provide a prompt for the programmer to select both the syringe type and size.
     - ~~b.~~**i.** Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient
   - ~~c.~~**b. Priming the Alaris Syringe Module**
     - i. Prime- tubing prior to attaching system to patient **with normal saline.**
     - ii. Attach administration set to syringe **and prime tubing with the medication that is ordered.**
     - iii. Once set is primed, close slide clamp
   - ~~d.~~**c. Loading the Alaris Syringe Module**
     - i. Prior to loading syringe, close roller tubing clamp to prevent uncontrolled flow
     - ii. Open syringe barrel clamp until it clears syringe chamber
     - iii. Twist gripper control clockwise and raise device head to fully extended position
     - iv. Insert syringe barrel flange between barrel flange grippers
     - v. Lock syringe in place by closing barrel clamp
     - vi. Twist gripper control clockwise then lower drive head
     - vii. Lock plunger in place with plunger grippers
   - ~~e.~~**d. Programming Guardrails see Infusion Pump: Infusion System with Guardrails Procedure**
   - ~~f.~~**e. Removing the Alaris Syringe Module**
     - i. Silence alarm
     - ii. Close roller tubing clamp
     - iii. Open plunger grippers and syringe barrel clamp
     - iv. Remove syringe by applying downward pressure to remove disc
   - ~~g.~~**f. Near End of Infusion**
     - i. The system will alternate between *NEAR END* and remaining **volume to be infused (*VTBI*).**
     - ii. The audio prompt requires being silenced just once and will not reoccur following initial silencing
   - ~~a. Documentation~~
     - ~~1. Document the start and change of syringe in the medical record~~
2. **PCA Syringe Module**
   - a. Select syringe type and size
   - b. Prime tubing prior to attaching tub**inge** to patient:
     - **i.** Option One: Manually express air from the administration tubing set **by:**
       - **1) Prime tubing prior to attaching system to patient with normal saline.**

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/08; 4/09	07/11; 03/15	08/11;03/15	05/15	10/11; 06/15	11/11, 07/15	11/11

2) Attach administration set to syringe and prime tubing with the medication that is ordered.

~~1)~~**3) Once set is primed, close slide clamp**

ii. Option Two: Prime tubing using Alaris PCA Module

1) The tubing may be primed from the *INFUSION MODE* Screen prior to programming the PCA Module

2) Select OPTIONS key

~~2.~~**3)** Press *PRIME SET WITH SYRINGE*

~~3.~~**4)** Press and hold *PRIME* key to prime tubing

~~4.~~**5)** Press *EXIT* when prime is complete

c. After priming tubing, close slide clamp

3. **Initial Set-Up**
   a. Label syringe per the Patient Controlled Analgesia Policy
   b. Load syringe with administration set attached
   c. Press *SYSTEM* ON key
   d. Select *YES* or *NO* to *"New Patient"*
   e. Select appropriate profile
   f. Press *CHANNEL SELECT* key
   g. Set key to Program position
   h. Press *CONFIRM* time setting
   i. Choose correct syringe type and size
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient
   j. Select correct medication and concentration
   k. Enter the dose and time limits
   l. Enter the total dosage patient may receive as ordered
   m. Responds to appropriate clinical advisory
   n. Close and lock door
   o. Attach administration set tubing set to patient
   p. Verify entered prescription with a second Registered Nurse
   q. Press *START* to begin PCA Module
   r. Document in the medical record per the Patient Controlled Analgesia Policy
4. **Changing Syringe**
   a. Press *PAUSE*
   b. Close roller tubing clamp
   c. Unlock door and remove old syringe
   d. Press *SILENCE*
   e. Date and time new syringe and attach to tubing
   f. Load new syringe
   g. Set key to PROGRAM position, close door
   h. Press *CHANNEL SELECT*
   i. Select correct syringe type and size
   j. Press *CONFIRM*
   k. Press *RESTORE*
   l. Verify entered drug, concentration, and settings
   m. Lock door and open roller tubing clamp
   n. Press *START*
5. **Administering a Bolus**
   a. Press *CHANNEL SELECT*
   b. Set key to PROGRAM position and enter authorization code
   c. Enter bolus dose amount and lock door
   d. Press *CONFIRM*
   e. Confirm settings and press *START*
   f. Document bolus in the medical record

6. **Reviewing History**
   a. Review patient history at the beginning of the shift and every four hours
   b. Press *CHANNEL SELECT* Key
   c. Press *OPTIONS*
   d. Press *PATIENT HISTORY*
   e. Review drug totals
   f. Press *ZOOM* key to review time intervals
   g. Press Detail to collect average dose per hour
   h. Press Main History
   i. To clear patient history, press *CLEAR HISTORY* and select *YES*
      i. Clear patient history every four hours and prior to transferring a patient to another nursing unit
   j. To view 24 hours totals, select *24 h Totals*
   k. Press *EXIT* after viewing history
   l. Press *START* to return to program
   m. Document patient history every four hours **in the patient's electronic medical record.** ~~on the Narcotic Medication Administration/Assessment Record~~

7. **Documentation**
   i. Document the start and change of syringes in the medical record.
   ~~b.~~**ii. A second RN must verify for accuracy the initiation, change in dosage or any boluses and document it in the EMAR.**

B. **REFERENCES:**

1. Cardinal Health. (201~~003~~-201~~405~~). Alaris syringe module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf
2. Cardinal Health. (201~~004~~-201~~405~~). Alari~~s~~e pca module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**6/05**	**SUBJECT:**	**Infusion Pumps, Intravenous (IV) Therapy**
REVISION DATE:	**4/07; 03/11**	**POLICY NUMBER:**	**IV.EE**

Clinical Policies & Procedures Committee Approval:	**~~01/11~~03/15**
Nursing Executive Committee Approval:	**~~01/11~~03/15**
Pharmacy & Therapeutics Committee Approval:	**05/15**
Medical Executive Committee Approval:	**~~02/11~~06/15**
Professional Affairs Committee Approval:	**~~03/11~~07/15**
Board of Directors Approval:	**03/11**

A. **PURPOSE**

1. To establish standards at Tri-City Medical Center for the management of **IV**~~intravenous~~ administration sets, solutions, and medications in order to decrease the incidence of infections, complications, and errors.

B. **DEFINITIONS**

1. **Back flushing** – A means to prime a secondary administration set in order to flush the secondary set of residual medication and/or to flush secondary tubing between the ~~delivery~~**deliveries** of incompatible medications.
2. **Channel** – The module attached to the programming module for the delivery of **IV**~~intravenous~~ fluids or medications.
3. **Channel Labels** – Provides a hospital-defined list of labels, which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., blood or chemotherapy), or the catheter location (i.e., pulmonary artery or ~~i~~intraperitoneal).
4. **Drug Library** – A drug dataset defines a list of up to 1500 drugs and concentrations appropriate for each Profile™. Programming via the drug dataset automates programming steps, including the drug name, drug amount and diluent volume, and represents established best practice Guardrails™ limit checking.
5. **Epidural** – Analgesia infusion delivered via the epidural space.
6. **Flush solution** – A solution used to provide a flush between or at the end of IV medications. The flush solution shall be compatible with the medications delivered.
7. **Guardrails™** – The programming software within the Alaris Medley infusion system designed to help prevent programming errors by:
   a. Providing an advisory prompt if an out-of-limit entry is made at the time the device is programmed to infuse medications defined in the drug library
   b. Comparing user programming with the hospital-defined best practice guidelines
   c. Customizing device configurable settings to meet the need of the selected patient population
8. **Intrathecal** – Analgesia infusion delivered through the intrathecal space.
9. ~~**PCA** – Patient-Controlled Analgesia~~
10. **Point of Care (POC)/Programming Module** – The module of the Alaris Medley medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module cannot deliver any medication without a pumping module. Each programming module has the ability to control four pumping modules.
11. **Priming Volume** – The amount of fluid used to clear the administration set of air. The amount of priming volume varies by administration set. The amount of priming volume can be found on the administration set package.

~~12.~~**11. Profile**™ – Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

~~13. **TPN** – Total parenteral nutrition~~

~~14. **VAD** – Vascular access device~~

C. **INTRAVENOUS INFUSIONS:**

1. All solutions and medications administered via an ~~intravenous~~ **IV** route shall be administered using an ~~intravenous~~ **IV** infusion device except in the following situations:
   a. IV push administration
   b. Surgery, under the direct supervision of an anesthesiologist
   c. Emergent situations, under the direct supervision of the Registered Nurse (RN)
   d. Identified research studies when the research RN is present to monitor the infusion
   e. High census, if there is a shortage of infusion pumps; plain solutions (without additives) at rates less than or equal to 75 mL/hour may be infused without an infusion pump
2. Staff must utilize both the appropriate Profile™ with Guardrails™ features and the channel labels when programming the Alaris infusion system to enhance the safe delivery of intravenous medications and solutions.
   a. ICU/ER/OR shall be used by ICU, P**ost A**n**esthesia** C**are U**n**it (PACU)**, **Cardiac** Cath**eterization** Lab, I**nterventional** R**adiology**, and E**mergency** D**epartment (ED), Surgery**
   b. IMC1/Tele shall be used by t**T**elemetry **and Forensics**
   c. Acute Care shall be used by 1N**orth**, Acute Rehab, 2P**avilion**, 3P**avilion**, 4P**avilion**, and the Forensic Unit
   d. NICU shall be used by N**eonatal I**n**tensive** C**are U**n**it (NICU)** and ED
   e. Peds1 shall be used by ~~3P~~, ED, and PACU
   f. **WNS (formerly** WCS**)** shall be used by L**abor** & D**elivery and Mother Baby**
   g. Oncology
3. Profiles and Channel Labels shall be checked by the licensed nurse **at the beginning of** each shift.
4. Profiles ™ shall be checked and changed as needed when a patient is transferred to another patient care unit. The receiving unit **RN** shall be responsible to check and change the patient profile.
5. Channel labels shall be utilized for medications and/or solutions that are not a part of the drug data set.

D. **PRIMING AND FLUSHING**

1. The priming volume shall be subtracted from the volume to be infused in order to ensure the medication and/or solution is infused over the prescribed rate as appropriate in NICU and Pediatrics.
2. To clear residual medication volume from the IV administration set, the back flushing technique shall be utilized. Approximately 20 mL of medication shall be flushed back into the empty bag or bottle. The flush solution is then infused at the same rate as the original rate of the medication.

E. **SMART SITE PORTS**

1. Smart Site injection sites **on the IV tubing** are accessed only with a luer lock syringe. **NOTE:** Using a needle or blunt tip syringe will damage the valve and result in leaking. The valve may be secured by attaching a Smart Site valve cap.

F. **CARE AND CLEANING**

1. One POC and channel shall be left in the patient's room at discharge and cleaned by Environmental Services (EVS). Extra POCs and channels shall be stored in a designated area on the unit or in the Sterile Processing Department (SPD).
   a. The tubing and IV bag shall be removed and discarded **by the unit's RN** prior to EVS cleaning pump.
   b. EVS shall not clean pump if tubing and/or IV bag have not been removed.

c. EVS shall attempt to locate the **Assistant Nurse Manager (ANM)** shift supervisor/designee and request the tubing and IV bag be removed. If the **ANM,** shift supervisor/designee cannot be located, or the tubing/IV bag is not removed in a timely manner, cleaning the pump shall be ~~N~~nursing's responsibility.

2. Cleaned infusion pumps shall be covered with a plastic bag.
3. Cleaning needs of the Infusion Pump during patient care shall be the responsibility of the RN caring for the patient.
   a. They shall be wiped down with a hospital-approved disinfectant weekly and when visibly soiled. (Refer to Infection Control Policy Manual, ~~Policy~~ **IC 9r Cleaning and Disinfection**, ~~section 3.2~~)
   b. To avoid damage to the connectivity points NEVER spray cleaning solutions directly onto the pump.
   c. Spray cleaning solution onto a cloth and wipe the pump with the moistened cloth.
4. Greater than 70% alcohol solutions are damaging to equipment surface, and shall not be used.
5. Infusion pumps shall be kept plugged into an electrical outlet at all times.
   a. Cleaned infusion pumps not in use shall be stored in the patient's room or designated storage area.
   b. Sterile Processing (SPD) shall make rounds (Monday-Friday) to maintain a minimum supply in SPD. (Exception Forensic Unit)

      ~~Refer to Administrative Policy, *Equipment: Maintenance & Repairs* for equipment malfunction/repairs.~~

G. **RELATED DOCUMENTS**

1. **Infection Control Policy Manual IC 9r Cleaning and Disinfection**

Tri-City Medical Center
Oceanside, California

~~STANDARDIZED PROCEDURE MANUAL~~PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) SCREENING

I. **POLICY:**

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

B. The following patient populations admitted to Tri-City Medical Center (TCMC) shall be tested for MRSA during pre-registration process or within 24 hours of admission:

1. The patient has been discharged from a general acute care hospital within 30 days prior to the current hospital admission.
2. The patient will be directly admitted to the Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU).
   a. This includes patients transferred into ICU from other medical units and neonates transferred into NICU from other hospital facilities.
3. The patient is receiving inpatient dialysis.
4. The patient is transferred from a skilled nursing facility.

~~A. The following patient populations admitted to TCMC shall be tested for MRSA during pre-registration process or within 24 hours of admission:~~

5. Patient with a ~~P~~previous history of MRSA **that meets both of the following criteria:**

a. The last positive MRSA culture is greater than 30 days ago and

~~1.~~b. Patient has not had an acute care admission in the last 30 days~~discharged from an acute care hospital greater than 30 days~~.

~~a.~~i. Place patient in Contact Precautions.

ii. Discontinue Contact Precautions if screening culture and other clinical cultures taken on the day of admission are negative.

1) Exception: Patients who were recently screened pre-surgery for MRSA and now are negative due to decolonization treatment. There is a high likelihood of re-colonization, so these patients will remain in Contact Precautions.

C. The physician/**Allied Health Professional** ~~or authorized designee~~ will decide to screen any "Patients who show evidence of increased risk invasive MRSA be screened for MRSA prior to discharge. This does not apply to patients who screened MRSA positive on admission."

~~C.~~D. The physician must order the screening test and the physician or authorized designee, will be responsible "to provide oral and written instructions regarding aftercare and precautions. ~~to prevent the spread of the infection to others."~~ (SB 1058, section 3, 1255.8, 4c and 4d)

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

~~E.~~F. See Infection Control Policy Management of Patients with MRSA for additional information.

II. **PROCEDURE:**

A. During the patient history/data collection the nurse shall determine if the patient meets the circumstances described above and shall record that information in the patient's medical record.

1. Documentation of the circumstances listed above will generate a task for nares cultures to "rule out MRSA."

B. The nurse shall obtain cultures when indicated within 24 hours of admission and send to the Tri-City Medical Center lab for processing.

1. Nares cultures

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Infection Control Committee	Pharmacy and Therapeutics	Interdisciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/08, 6/10, 5/12; 1/15	05/12; 2/15	05/12; **02/15**	**04/15**	05/12; **03/15**	05/12, **05/15**	07/12; **6/15**	**07/15**	07/12

a. Swab both nares with attention to swabbing the anterior portion of the nares.
   i. For adult patients, use one culturette swab for both nares.
   ii. For pediatrics patient, use one culturette swab for both nares.
   iii. For neonates, use one nasopharyngeal swab for both nares.
b. Swab nose using same swab to both nostrils being careful not to touch outside of nose.
c. Insert swab ½ – 1 inch into nares gently rotating swab in a clockwise then counter clockwise 2 – 5 times pressing gently into the nasal septum.
d. Return swab into transport medium being careful not to touch sides of container.
e. Label the culture in accordance with Patient Care Services procedure, Specimen Handling and include "rule out MRSA," this allows the lab to screen for only this organism.

C. Tri-City Medical Center's clinical microbiology lab shall process nares cultures received to "rule out MRSA" using a selective agar plate.
   1. If the patient tests positive for MRSA:
      a. The patient will be placed in Contact Precautions in accordance with Infection Control Policy IC 5, Standard and Transmission Based Precautions.
      b. Micromedex pre-printed MRSA education shall be provided to the patient or the patient's representative.

III. DOCUMENTATION

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

IV. RELATED DOCUMENTS

A. Patient Care Services procedure, Specimen Handling
B. Infection Control Policy Standard and Transmission Based Precautions
~~b.~~C. Infection Control Policy Management of Patients with MRSA

~~III.~~V. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

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

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

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

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

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

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY~~ MANUAL

ISSUE DATE:	**12/93**	**SUBJECT:**	**Pain Management**
REVISION DATE:	**05/94, 08/97, 09/00, 07/03, 05/05, 04/06; 11/07; 4/08, 11/08, 12/08, 1/12;**	**POLICY NUMBER:**	**IV.W**

Clinical Policies & Procedures Committee Approval:	**~~07/12~~ ~~06/14~~ 04/15**
Nurse Executive Committee Approval:	**~~08/12~~ ~~06/14~~ 04/15**
Pharmacy & Therapeutics Committee Approval:	**~~07/14~~ 04/15**
Medical Executive Committee Approval:	**~~11/12~~ ~~08/14~~06/15**
Professional Affairs Committee Approval:	**~~01/13~~~~11/14~~07/15**
Board of Directors Approval:	**~~01/13~~11/14**

A. **PURPOSE:** To use effective pain management techniques to provide appropriate pain relief designed for each patient on an individual basis.

B. **POLICY:**

1. Pain management begins with the assessment of the patient's level of pain at the time of admission, continues throughout their stay, and is considered in discharge planning.
   a. Perform a pain assessment with each patient report of new or different pain
2. Pain management is an interdisciplinary process.
3. All patients have a right to pain relief and shall receive pain management.
4. The patient (including neonatal, pediatric, adolescent, and adult) and family/caregiver are educated about the following as appropriate to his/her condition and assessed needs for understanding:
   a. Pain
   b. Risk for pain
   c. Importance of effective pain management
   d. Pain assessment process
   e. Methods for pain management
5. Patient shall be assured of adequate pain management.
   a. Information shall be obtained from the patient and/or family/caregiver as appropriate with regard to cultural, ethnic, and/or religious preference in determining methods of pain management (e.g. pharmacologic versus non-pharmacologic).

6. Pain level assessment is considered the "fifth" vital sign. Assessment and reassessment of pain level and pain relief shall be performed with routine vital signs and as needed. Findings shall be documented in the medical record.

~~6.~~**7.** **All patients will be assessed for sedation~~/over-sedation~~ prior to administration of opiates. The Registered Nurse (RN) should also consider concurrent medications that the patient is receiving that can cause an increased sedative effect (i.e. muscle relaxers, tramadol, benzodiazepines and antihistamines)~~and medications commonly used for pain known to cause sedation (for example hydromorphone, hydrocodone and dilaudid) as well as following their administration (see list of Commonly Used Pain Medications Known to Cause Sedation)~~.**

~~7.~~**8.** Health care providers shall maintain patient safety while managing the patient's pain.

~~8.~~**9.** An appropriate pain rating scale shall be used to assess pain that is consistent with the patient's age, condition, and ability to understand. (see Attachment A):

C. **PROCEDURE:**

1. Provide a calm, supportive atmosphere.
2. Assess patient's characteristics of pain consistent with the patient's age, condition, and ability to understand (may include but is not limited to*):*
   a. Acceptable pain level
      i. If patient is unable to verbalize acceptable level, document reason in the medical record.
      ii. If condition changes and patient is able to verbalize acceptable pain level, the level must be documented.
   b. Physical, behavior, and emotional signs and symptoms of pain
      i. Presence of pain
      ii. Physical exam and observation of pain site as clinically indicated which may include intensity, location, quality, duration, alleviating factors and/or aggravating factors.
3. Document pain assessment in the medical record.
~~3.~~**4. For opiates, ~~D~~document pre and post-intervention sedation level using ~~Pasero Opiate Sedation Scale (POSS)~~ the appropriate sedation scale (see Sedation Evaluation Resource Guide~~Attachment 3)~~**
~~4.~~**5. Call the physician/Allied Health Provider for clarification** ~~W~~**w**hen multiple pain medications are ordered for the same patient without a designated pain level~~, the physician will be called for clarification~~ (see Patient Care Services Policy Medication Administration).
   ~~5.~~**a.** Pain levels are defined as:
      ~~a.~~**i.** Mild pain (pain level 1 – 3)
      ~~b.~~**ii.** Moderate pain (pain level 4 – 7)
      ~~c.~~**iii.** Severe pain (pain level 8 – 10)
6. **Perform appropriate interventions** ~~B~~**b**ased on the patient's stated pain level~~, appropriate interventions shall be performed~~ as needed to achieve patient's acceptable pain level.
   a. Pharmacologic interventions require a physician**/Allied Health Provider** order.
   b. Non-pharmacologic interventions that do not require a physician**/Allied Health Provider** order may include the following:
      i. Children, adolescents, adults:
         1) Distraction
         2) Positioning
         3) Relaxation
         4) Music therapy
         5) Guided imagery
         6) Massage
         7) Range of motion
         ~~7)~~**8) Heat or cold therapy**
      ii. Infants:
         1) Swaddling
         2) Holding
         3) Repositioning
         4) Pacifier
         5) Oral Sucrose
   c. Non-pharmacologic interventions that require a physician **/Allied Health Provider** order may include the following:
      i. ~~Heat or cold therapy~~**Mechanical devices providing heat or cold therapy**
      ii. Transcutaneous Electrical Stimulation (TENS)
   d. Reassessment of pain level **and level of consciousness~~potential medication-induced sedation~~ should**~~shall~~ be done thirty-sixty (30-60) minutes after intravenous, intramuscular, or subcutaneous intervention. Document in PRN response in medical record.

e. Reassessment of pain level **and level of consciousness** ~~**potential medication-induced sedation should**~~ ~~shall~~ be done one (1-~~2~~) hour ~~(s)~~ after PO intervention. Document in PRN response in medical record.

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

~~f.~~**g.** Notify the physician/**Allied Health Provider** if pain is not relieved ~~by non-pharmacologic further interventions obtained pain is not relieved by interventions~~ within one (1) hour and no other interventions are available to the patient.

i. If the patient refuses pain intervention measures/procedures, the care provider shall discuss the patient's pain management goals with the patient and reassess potential interventions. Refusal of pain management intervention, reassessment findings, and discussion with patient regarding pain management shall be documented in the medical record.

~~i.~~**h.** **Notify the pysician/Allied Health Provider if patient continues to report unacceptable pain level, but is not eligible to receive additional interventions due to excessive sedation.**

7. **Educate** ~~**P**~~**p**atient ~~teaching~~ regarding pain management **and** ~~shall be~~ documente~~d~~ **education** in the medical record.

~~8.~~**a.** The "Patient's Rights Regarding Pain Control" is located in the Patient Handbook.

~~9.~~**8.** **Consider** ~~**P**~~**p**atient/~~**F**~~**f**amily preferences, as well as cultural, ethnic, and religious beliefs, ~~shall be considered~~ when determining the pharmacological and non-pharmacological methods to be used for pain management.

D. **SPECIAL CIRCUMSTANCES:**

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

iv. Utilize presumptive treatment of pain for patients who cannot speak and who undergo painful treatments or procedures.

v. Utilize a non-verbal pain scale (for example NVPS or CNPI or CPOT)

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

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

E. **SAFETY**

1. Discontinue PCA in patients with deteriorating level of consciousness and notify the physician/**Allied Health Provider**.
2. Instruct family/caregivers to report patient's pain or inability to use PCA to the nurse. Family/caregivers should not push PCA button for patient.
~~2.~~**3. Inspect all of patient's medications and identify those with potential to cause sedation (e.g opiates, benzodiazepines, anticonvulsants etc.). Use all sedating medications with caution as their effect may be additive.**
~~3.~~**4.** ~~In patients receiving intrathecal or epidural opioids, c~~**C**larify any supplemental pain medication ordered by physician/**Allied Health Provider** other than anesthesiologist with the anesthesiologist before administration in patients receiving intrathecal or epidural opioids.
~~4.~~**5.** Monitor the use of ice or heat therapy and the use of transcutaneous electrical nerve stimulation (TENS) patches at least every four hours for the development of burns and/or skin breakdown.
~~5.~~**6.** Inspect site of fentanyl patches every shift for evidence of inflammation.
~~6.~~**7.** Observe patients who are receiving a narcotic/opioid for ~~their individual response~~ **excessive sedation following administration**. *Naloxone should be readily available to antagonize enough narcotic so that the patient is able to maintain adequate ventilation but leaves enough opioid available in the system to relieve pain.
~~7.~~**8.** Avoid abrupt discontinuation of an opioid in a known or suspected physically dependent patient.
~~8.~~**9.** Regulate all continuous IV pain medications on an infusion pump.
~~9.~~**10.** Notify physician/**Allied Health Provider** for any unrelieved pain.
~~10.~~**11.** Report to the physician/**Allied Health Provider** any signs/symptoms of over sedation or any other unexpected physiological and behavioral outcomes:
   a. Apnea
   b. Respiratory rate less than 10 breaths per minute or less than 20 breaths per minute for children under 2 years of age
   c. $Sp0_2$ less than 92% or as ordered
   d. Hypotension
   e. Allergic reactions
   f. Change in level of consciousness (e.g. unresponsive, somnolent, difficult to arouse)
   g. Nausea/vomiting
   h. Itching
   i. Urinary retention
   j. Absent bowel sounds

F. **~~ATTACHMENTS~~ FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER):**

1. Adult Pain Evaluation Resource Guide
   a. Numeric Scale
   b. Wong-Baker Face Scale
   c. Adult Non-Verbal Pain Scale (NVPS)
   d. Ventilated Patient Non-Verbal Pain Scale (NVPS)
   e. Proxy Pain Rating
2. Pediatric Pain Evaluation Resource Guide
   a. Numeric Scale
   b. Wong-Baker Face Scale

c. Behavioral Scales (FLACC)
   i. FLACC
   ii. Neonatal Pain, Agitation, and Sedation Scale (NPASS)

~~ii.3. Commonly Used Pain Medications Known to Cause Sedation List~~

~~3.~~**4. Sedation Evaluation Resource Guide ~~(POSS)~~**~~TCMC Medical Staff Recommended Pain Therapies~~

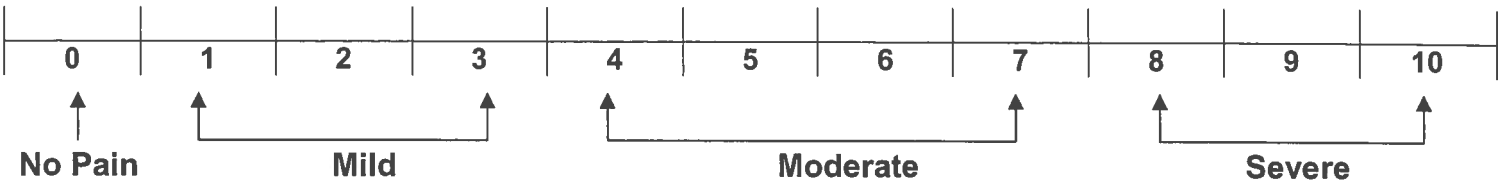
G. **REFERENCES:**

1. California Healthcare Association Consent Manual Health and Safety Code Section 124960. (20~~0~~15).
2. ~~Odhner, M., Wegman, D., Freedland, N., and et al.. (2003). Assessing pain control in nonverbally critically ill adults. Dimens Crit Care Nurs, Volume 22/6~~
3. Amis, D. and Green, J. (2004). Assessment of effective coping during labor. Lamaze International Retrieved April 24, 2008. www.lamaze.org.
4. ~~National Association of Neonatal Nurses. (2006). Guidelines for neonatal nursing policies, procedures, competencies, and clinical pathways.~~
~~4.~~**5. Altimier, L., Brown, B., & Tedeschi, L. (2011). *Neonatal nursing policies, procedures, competencies, and clinical pathways*, 4 ed. Glenview, IL: National Association of Neonatal Nurses.**
6. Gomella, T.L. (2013). Neonatology: management, procedures, on-call problems, diseases, and drugs,7ed. New York, NY:McGraw Hill Education.
7. Pain Assessment (Neonatal). (2013). Mosby's Nursing Skills. Retrieved from http://app44.webinservice.com/NursingSkills/Home.aspx
~~5.~~**8. Lehr, V., Cortez, J., Grever, W., & Cepeda, E. Randomized Placedbo-Controlled Trial of Sucrose Analgesia on Neonatal Skin Blood Flow and Pain Response During Heel Lance. *Journal of Pain*.**
~~6.~~**9.** ~~American Academy of Pediatrics. (2006). Sucrose analgesia: Identifying potentially better practices.~~
~~7.~~**10.** Jarvis, C. (2012). Physical Examination and Assessment. St. Louis: Elsevier Saunders.
11. Pasero C, McCaffery M. (2011): *Pain Assessment and Pharmacologic Management.* St. Louis: Mosby/Elsevier.

ATTACHMENT A

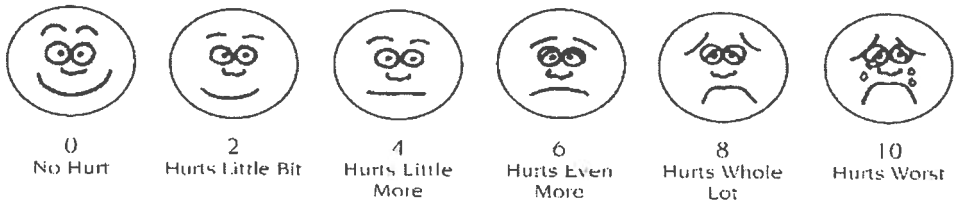
ADULT PAIN EVALUATION RESOURCE GUIDE

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



2. **WONG – BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



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

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

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

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

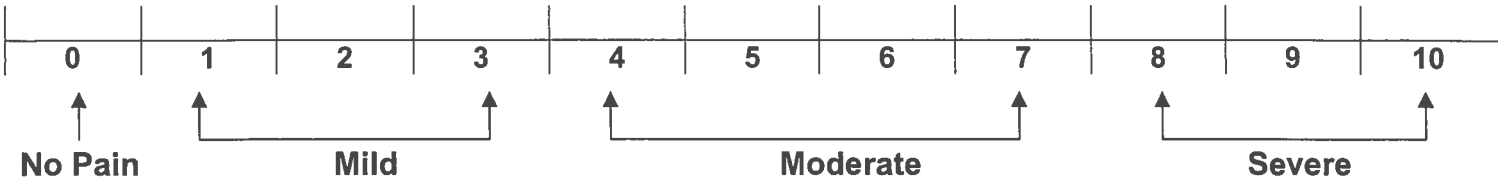
5. **PROXY PAIN RATING:** The family or caregiver thinks the patent is in pain.

Proxy Pain Rating: **No pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

ATTACHMENT B

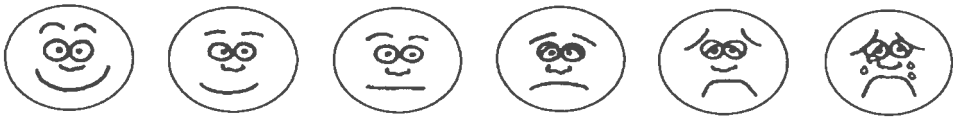
PEDIATRIC/NEONATAL PAIN EVALUATION RESOURCE GUIDE

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



2. **WONG- BAKER FACES**

CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



0 No Hurt | 2 Hurts Little Bit | 4 Hurts Little More | 6 Hurts Even More | 8 Hurts Whole Lot | 10 Hurts Worst

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

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

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

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

Neonatal Infant Pain Scale (NIPS)

Parameter	Finding	Points
facial expression	**relaxed**	**0**
	grimace	**1**
cry	**no cry**	**0**
	whimper	**1**
	vigorous crying	**2**
breathing patterns	**relaxed**	**0**
	change in breathing	**1**
arms	**restrained**	**0**
	relaxed	**0**
	flexed	**1**
	extended	**1**
legs	**restrained**	**0**
	relaxed	**0**
	flexed	**1**
	extended	**1**
state of arousal	**sleeping**	**0**
	awake	**0**
	fussy	**1**

~~Attachment 3:~~Sedation Evaluation Resource Guide

Pasero Opioid-induced Sedation Scale (POSS) with Interventions

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

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

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

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

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

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

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

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

Ramsey Scale

Level of sedation for adults using the Ramsey Scale:

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

Richmond Agitation Sedation Scale (RASS)

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

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**POWER INJECTION PROCEDURE FOR PERIPHERALLY INSERTED CENTRAL CATHETER (PICC)**
Purpose:	To outline the RN's responsibility when attaching and disconnecting a Power Injectable Peripherally Inserted Central Catheter with the Contrast Power Injector. Maintain compliance with state and manufacturers guidelines.
Supportive Data:	The Power Injectable CT PICC is indicated for short or long term peripheral access to the central venous system for intravenous therapy and power injection of contrast media. For blood sampling, infusion, or therapy use a 5 French or larger catheter. The maximum recommended infusion rate is 4 milliliter/sec for power injection of contrast media. The maximum pressure of power injectors used with the Power Injectable CT PICC may not exceed 250 psi.
Equipment:	Power Injectable CT PICC, Power Injector, Computerized Axial Tomography Scanner / MRI Scanner. 1. Non-sterile gloves. 2. 3 alcohol swabs 3. Sterile field (may use 4x4 sterile gauze) 4. 10mL or more Sterile Normal Saline filled syringe 5. 1 Anti-reflux valve for each lumen.

A. **POLICY:**

1. **Use only lumens marked "Power Injectable" for power injection of contrast media.**
   a. **Warning:** Use of lumens not marked "Power Injectable" for power injection of contrast media may cause failure of the catheter.
2. Confirm injection flow rate does not exceed capacity of 5 French double lumen PICC line with technologist.
   a. **Warning:** Exceeding the maximum flow rate of 4 mL/sec may result in catheter failure and/or catheter tip displacement.

B. **PROCEDURE PERFORMED BY A REGISTERED NURSE:**

1. Perform hand hygiene.
2. Don clean non-sterile gloves.
3. Clamp both PICC ports and suspend all **Intravenous** (IV) meds and **Total Parenteral Nutrition (TPN)**.
4. Select port to be used and ensure patency.
   a. **Warning:** Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure.
   b. Cleanse catheter tip thoroughly with three (3) alcohol swabs and allow to air dry.
   c. Attach a 10 mL or larger syringe filled with sterile normal saline.
   d. Unclamp and aspirate for adequate blood return and flush the catheter with the full 10 mL or more of sterile normal saline.
5. ~~Clamp PICC~~.
6. Detach syringe.
7. Attach the IV tubing from the power injector syringe directly to the PICC with the anti-reflux valve attached.
8. ~~Unclamp~~ **Keep** PICC to be used for power injection **unclamped** while keeping secondary catheter lumen not connected to power injection system clamped.
9. Notify technologist that the system is connected.
10. Monitor PICC and injection site while the injection is under way. Immediately notify technologist if of any abnormal infiltration, leaking or catheter failure.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Pharmacy & Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/06; 6/08; 11/09	11/09; **03/15**	12/09; **03/15**	**05/15**	**06/15**	2/10, **07/15**	2/10

11. Exit the room upon request of the technologist to avoid any exposure to radiation. Technologist will give a 10 second warning announcement.
12. After imaging is complete, ~~clamp PICC and~~ disconnect the power injection tubing.
13. Flush the Power PICC with 10 mL of sterile normal saline, using a 10 mL or larger syringe.
14. Resume previous IV fluids or clamp unused port.

C. **RELATED DOCUMENTS:**

1. Infection Control Policy IC8 Hand Hygiene
2. Patient Care Services Central Venous Access Procedure

D. **REFERENCES:**

1. Bard Access Systems Power PICC. Polyurethane Radiology Catheters with Microintroducer Set, Instructions for Use. **http://powerpicc.com/clinician-info.php** ~~Revised May 2008.~~ **2014**
2. Angiodynamics, Inc. Morpheus CT PICC Insertion Kit, **http://www.angiodynamics.com/products/morpheus-smart-picc**~~May~~ 201~~4~~08.
~~3. ICU Medical, Inc. memo 06/2008~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 1/06

SUBJECT: **Restraints, Used for Non-Violent/Non-Self-Destructive Behavior**

REVISION DATE: 6/07; 08/09; 10/09; 01/11 07/11; 08/12; 3/15

~~POLICY NUMBER: IV.Q.1~~

Clinical Policies & Procedures Committee Approval:	**~~08/12~~05/15**
Nursing Executive Council Approval:	**~~08/12~~05/15**
Medical Executive Committee	**~~09/12~~06/15**
Professional Affairs Committee Approval:	**~~10/12~~07/15**
Board of Directors Approval:	**11/12**

A. **PURPOSE:**

1. To provide a consistent standardized organizational-wide policy for the use of non-violent/non-self-destructive behavior restraint.

B. **PHILOSOPHY:**

1. Tri-City Healthcare District acknowledges restraint may be necessary for certain patient populations.
2. Restraint shall only be used when essential to protect patients from harming themselves, other patients, or staff.
3. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event ~~seclusion or~~ restraint of a patient becomes necessary, **Tri-City Medical Center** (TCMC) supports a philosophy~~,~~ which will protect the patient's health and safety and preserves his/her dignity, rights and well-being.
4. Restraints of any type should not be used as a punishment, retaliation, coercion, or for the convenience of staff, and should be discontinued as soon as possible.
5. All patients are given information regarding patients' rights upon admission.
~~4.~~**6. The use of restraint is not based on a patient's restraint history or behavior history.**

C. **DEFINITIONS:**

1. Restraint – Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.
   - **a.** Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.
   - ~~a.~~**b. Chemical restraint or seclusion are not used for non-violent behaviors~~restraints~~.**
   - ~~b. Chemical Restraint: A drug or medication used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A PRN order does not determine the use of a drug as a restraint. Criteria for "standard treatment or dosage" are treating a specific patient's clinical condition of symptoms, not behaviors, which would enable the patient to function more effectively and appropriately (not a restraint) rather than reduce the patient's ability to interact with the world around them (restraint).~~
     - i. ~~Emergency Medication: It may be necessary to use psychotropic agents to control severe agitation. Medications ordered and taken voluntarily on a PRN basis as indicated for the psychiatric condition being treated are not considered chemical restraint. Emergency medication given against a patient's will is not considered a~~

~~chemical restraint if it is for the treatment of acute symptoms of a psychiatric illness.~~

~~2. Seclusion – The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion is a form of restraint that may be used only for the management of violent or self-destructive behavior.~~

2. Physical Escort – A physical escort would include a "light" grasp to guide~~escort~~ the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.

3. ~~Licensed Independent Practitioner (LIP) – An individual permitted by State law and by the hospital to order restraints and seclusion for patients independently, within the scope of the individual's license and consistent with individually granted clinical privileges. Physicians and other LIPs authorized to order restraint or seclusion will have a working knowledge of this policy.~~

4. Practitioner – any physician, dentist, or podiatrist ~~who is applying for Medical Staff membership and/or clinical privileges or~~ who is a Medical Staff member and/or who exercises clinical privileges at TCMC as context requires, unless otherwise expressly limited.

~~3.~~5. Qualified/Specially Trained Staff – Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served.

D. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
   ~~a. Side rails used for safety or support would not be considered restraints.~~
2. For the purposes of this policy, the following are ***not*** considered restraint:
   a. Side rails used for safety or support
   ~~a.~~b. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure ~~(~~i.e., surgical positioning, **intravenous (**IV**)** arm boards, papoose, protection of surgical and treatment sites in pediatric patients~~)~~.
   ~~b.~~c. Adaptive support in response to assessed patient needs ~~(~~i.e., orthopedic prescribed devices, postural support, table top chairs~~)~~.
   ~~c.~~d. Protective equipment such as helmets.
   e. Hand mitts (gloves only) to keep from scratching self **that are not secured (tied) to a bed frame or chair**
      ~~d.~~i. ~~(if~~ pinning wrists down with mitts **and/or**~~,~~ hand or fingers are immobilized **are** ~~, this is~~ considered a restraint~~)~~.
   f. Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm
   ~~e.~~g. Devices that permit the patient to participate in activities without the risk of physical harm
   ~~f.~~h. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes ~~(~~i.e., handcuffs, shackles~~)~~.
   ~~g. Restraint use for violent or self-destructive behavior (the restraint standards for violent or self-destructive behavior apply).~~
3. Safe transportation of patients on or off the unit for procedures or tests:
   a. Patients may be secured in a transport gurney or chair with a safety device (i.e. Velcro strap, side rails) upon transport on or off the unit.
   b. Patients may be secured with a safety device while obtaining a procedure or test.
   ~~b.~~c. Patients may not be left unattended.

4. **Restraint use for violent or self-destructive behavior (the restraint standards for violent or self-destructive behavior apply). See the Patient Care Services Restraints/Seclusion for Violent/Self-Destructive Behavior Policy which includes definitions for the following:**
   - **a. Chemical Restraint**
   - **b. Time-out**
   - **c. Physical Escort**
   - **d. Physical Holds**
   - **e. Qualified/Specially Trained Staff**

E. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. ~~Prone restraint is prohibited.~~ Restraining of patient in the prone position may predispose the patient to suffocation. **Prone restraint is prohibited.**
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room not under continuous observation by staff is at greater risk for self-injury or adverse occurrences.

F. **ORDERS:**

1. Restraint is used upon the order of a **practitioner**~~Medical Doctor (MD)/Licensed Independent Practitioner (LIP) or designee~~.

~~1.~~**2.** **Practitioner**~~Physician~~ orders are valid until criteria for release is met.

~~2.~~**3.** If a **practitioner**~~MD/LIP~~ is not available to issue such an order, a Registered Nurse (RN) may initiate restraint use based on an appropriate assessment of the patient.

a. Once placed in restraints, a **practitioner**~~MD/LIP~~ shall be notified as soon as possible of the initiation of restraint, and a ~~verbal~~**telephone** or written order shall be obtained from that practitioner and entered in the patient's medical record.

~~3.~~**b.** If the initiation of restraint is based on a significant change in the patient's condition, the RN shall immediately notify the **practitioner**~~MD/LIP~~.

4. The attending physician must be consulted as soon as possible if restraint is not ordered by the patient's attending physician.
5. A written order, based on examination of the patient by a **practitioner**~~MD/LIP~~, is entered into the medical record ~~within 24 hours of~~**on** the initiation of restraint.
6. Orders for restraint are not written as standing orders or on an as needed basis ~~(~~i.e., PRN~~)~~.
7. Orders for non-violent/non-self-destructive restraint must include: action justifying restraint, type of restraint, **and** criteria for release~~., contributing diagnosis and new medications.~~
8. The RN shall assess the discontinuation of the use of restraints as soon as **it** is safely possible.
9. **When restraint is discontinued and/or** ~~If~~ alternatives **methods** are not effective and restraint must be reapplied, a new order must be obtained.

G. **INITIATION AND /DOCUMENTATION:**

1. Alternatives must be considered and tried before using restraint. Refer to examples of alternative interventions on Appendix A.
2. If alternatives are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
3. The RN shall document initiation of restraint **in the medical record on the appropriate restraint electronic form or paper restraint flowsheet. The following shall be documented:**

~~3. Time and date on the electronic form or paper restraint flowsheet on Restraint Non-Violent Behavior Initiation Powerform or 24 hour restraint flowsheet including:~~

a. Restraint ~~Type~~ **Reason i.e., Non-violent/ Non-Self Destructive Behavior Restraint** ~~r~~

b. Restraint Initiation Date and Time
c. Restraint ~~t~~Type **i.e., chair with lap table, mittens tied to bed, soft ankle, soft wrist, vest**
d. ~~,~~ Restraint Location i.e., left or right upper or lower extremity, torso
e. ~~location,~~**Action Justifying use of Restraint**
f. ~~contributing diagnosis, time initiated, behavior necessitating the use of restraint,~~ ~~d~~Description of other behavior requiring restraint, **if applicable**
g. ~~, p~~Pre-restraint alternatives attempted ~~including the patient's response and patient/family education.~~
h. Effectiveness of Pre-restraint alternatives
~~4.~~**i. Education provided to patient/family education**

H. **ONGOING MONITORING AND /DOCUMENTATION:**

1. ~~Observation~~**Patient in restraint may need more frequent monitoring because of age, physical or mental conditions or other needs/conditions based on clinical judgment and knowledge of the patient and their individual needs**
2. If the patient is sleeping, the RN shall observe the patient to ensure a safe environment.
~~1.~~**a. Clinical judgment and knowledge of the patient and their individual needs shall be used to determine when and what items need to be evaluated.**
~~a. The RN or designee trained and competent in use of restraint shall visually observe patient at least every 60 minutes while restrained.~~
~~2.~~**3. Patient Care**
a. The RN or designee trained and competent in use of restraint shall address **and document** the following patient care needs at least every 2 hours
i. Range of Motion (when awake)
ii. Elimination and hygiene
iii. Nutrition/Hydration
iv. Allowance for the patient to have maximum movement

~~a. : restraint activity, type, location, skin/circulation and ROM/positioning, nutrition/hydration, hygiene/elimination, safety, whether the restraint has been appropriately applied, removed or reapplied and shall document on the Restraint Non-Violent Behavior Monitoring Powerform or 24 hour medical restraint flowsheet.~~

~~3.~~**4. Assessment and Reassessment**
a. The RN shall reassess patients in medical restraint every 2 hours or more frequently if necessary including.
b. The patient will be assessed for the following:
i. Mental status and behavior
ii. Physical/emotional well-being
iii. Respiratory status
iv. Limb circulation
v. Maintenance of the patient's rights, dignity, and security
vi. Monitoring of the correctness of the application, removal and reapplication of restraint
~~a.~~**vii. Skin** ~~: appropriate application of restraint, feasibility of use of least restrictive method, feasibility of removal of restraint and assessment of mental status and behavior and document on the Restraint Non-Violent Behavior Monitoring Powerform or 24 hour medical restraint flowsheet.~~
~~i. Restraint may be removed and alternatives attempted.(Document removal in the medical record.)~~
~~ii. If alternatives are not effective and restraint must be reapplied, a new order must be obtained.~~
c. Document assessment and reassessment findings in the medical record.
~~b. Patient in restraint may need more frequent monitoring because of age, physical or mental conditions or other needs or conditions based on clinical judgment and knowledge of the patient and their individual needs.~~

~~c. If the patient is sleeping, the nurse shall observe the patient to ensure a safe environment. Clinical judgment and knowledge of the patient and their individual needs shall be used to determine when and what items need to be evaluated.~~

I. PLAN OF CARE

1. **Ensure the appropriate (IPOC) is implemented with the initiation of restraint.**
   a. **Review and update per the IPOC policy.**
~~l.~~2. **Discontinue the restraint IPOC when restraint is discontinued**

J. PATIENT/FAMILY EDUCATION

1. **The following education shall be provided to the patient/family:**
   a. **Clinical reason for restraint**
   b. **Purpose and use of restraint**
   c. **Monitoring and care that shall be provided**
   d. **Criteria necessary for termination of restraint**
   e. **Additional information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient**
2. **Appropriate family members shall be notified when a patient is placed in restraint when it meets with the patient's wishes and/or Health Insurance Portability and Accountability Act (HIPAA) and other regulatory standards.**

K.

~~J.~~L. DISCONTINUATION/~~DOCUMENTATION~~

1. Restraint shall be discontinued when criteria for release are met.
~~1.~~2. ~~and d~~Documente~~d~~ **discontinuation of restraint** ~~on the~~ **in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.** ~~Restraint Non-Violent Behavior Monitoring Powerform or 24-hour medical restraint flowsheet.~~

~~K.~~M. COMPETENCY AND EDUCATION

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the **application and monitoring** ~~use of medical~~ restraint, and shall undergo education and training in the proper and safe use of restraint during initial orientation and annually thereafter.
~~1.~~2. Training requirements include but are not limited to:
   a. The determination of who has authority to order restraint ~~and seclusion~~
   b. The determination of who has authority to discontinue the use of restraint ~~or seclusion~~
   c. The determination of who can initiate the use of restraint ~~or seclusion~~
   d. The circumstances under which restraint ~~or seclusion~~ is discontinued
   e. The requirement that restraint ~~or seclusion~~ is discontinued
   f. A definition of restraint
   ~~g. A definition of seclusion~~
   ~~h.~~g. A definition or description of what constitutes the use of medications as a restraint
   ~~i.~~h. A determination of who can assess and monitor patients in restraints ~~or seclusion~~
   ~~j.~~i. Time frames for assessing and monitoring patients in restraints ~~or seclusion~~
3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring ~~process~~ of restraint.
   ~~2.~~a. ~~In addition, there shall be a~~ **A** qualified staff member **shall be** assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure proper safety procedures, orders and monitoring are implemented.
~~3.~~4. **Practitioners**~~Physicians and LIPs~~ shall be educated in the use of restraint

~~L.~~N. STAFFING

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, co-occurring conditions, patient acuity, age, and developmental functioning of the patient. These elements are addressed in the staffing mix of the unit.

~~M. PATIENT/FAMILY EDUCATION~~

~~1. The following education shall be provided to the patient:~~
~~a. Clinical reason for restraint~~
~~b. Purpose and use of restraint~~
~~c. Monitoring and care that shall be provided to patient~~
~~d. Criteria necessary for termination of restraint~~
~~e. Any other information necessary to assure the safety and comfort, dignity, preservation of rights and well being of the patient~~

~~2. Appropriate family members shall be notified when a patient is placed in restraint when it meets with the patient's wishes and/or HIPAA and other regulatory standards.~~

~~N. PLAN OF CARE~~

~~1. The plan of care will be modified according to the use and discontinuation of restraints.~~

O. **NOTIFICATION**

1. The hospital shall report **required information** to Center**s for**~~of~~ Medicare **and** /Medicaid Services (CMS) per regulations. **See the examples below:**
a. Each death that occurs while a patient is in restraint or seclusion
b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
~~1.~~**c. Each death known to the hospital that occurs within one week after restraint or seclusion was used**

2. Regulatory Compliance shall document in the patient's medical record the date and time the death was reported to CMS.

P. **PERFORMANCE IMPROVEMENT**

1. Data shall be collected- on ~~all occurrences of~~ restraints and ~~quarterly~~ submitted to the **Restraint Committee and reviewed by the Joint Commission Committee** ~~appropriate council/committee~~ to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement.
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.

Q. **REFERENCES**

1. California Code of Regulations. ~~(2009).~~ Title XXII.
2. Department of Health and Human Services. ~~(2009).~~ *Federal registry part IV. Centers for Medicare and Medicaid Services (CMS) 42CFR part 482.*
~~1.~~**3.** Joint Commission (201~~2~~**5**). *Hospital ~~A~~accreditation ~~S~~standards.* Retrieved from http://www.jointcommission.org
~~2. California Code of Regulations. (2009). Title XXII.~~
~~3. Department of Health and Human Services) Federal Registry Part IV). (2009). CMS 42CFR Part 482.~~

Restraint Education/ Competency Based Upon Scope of Practice

Restraints for Non-Violent/Non-Self-Destructive Behavior	Registered Nurse	CNA/ NA ACT/MHW/ET	Rad. Tech	Transporter Lift Team	Physical Therapist/ RCP	Occupational Therapist	Security	~~Behavioral Health Liaison~~	~~BHU Assistant Nurse Manager/Charge Nurse~~	**Regulatory** ~~Risk Management~~
Initiation	✓									
Orders	✓									
Pre-Restraint Alternatives	✓	✓								
Ongoing Monitoring	✓	✓								
Observation	✓	✓								
Patient Care	✓	✓								
Assessment/Reassessment	✓									
Discontinuation	✓									
Documentation	✓	✓	✓		✓	✓				
Release and/or Re-secure	✓	✓	✓	✓	✓	✓	✓			
Report restraint related death to CMS										✓
Document CMS notification in Patient's medical record										✓
~~Restraints/Seclusion for Violent/Self-Destructive Behavior~~										
~~Handle immediate situation~~	~~✓~~	~~✓~~		~~✓~~			~~✓~~			
~~Call Behavioral Health for assistance in requirements~~	~~✓~~									
~~Complete 1 hour face-to-face evaluation~~									~~✓~~	
~~Debriefing~~	~~✓~~							~~✓~~	~~✓~~	

✓= Required for scope of practice

APPENDIX A: ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives

- Diversion activities such as: television, soothing music, books, or folding washcloths
- Family interaction
- Orientation to day, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values
- Pharmacy consult

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 1/06

SUBJECT: Restraints/Seclusion for Violent/Self-Destructive Behavior

REVISION DATE: 6/07; 08/09; 10/09; 09/10; 12/11;10/14

~~POLICY NUMBER: IV.Q.2~~

Clinical Policies & Procedures Committee Approval: ~~12/11~~05/15
Nurse Executive Committee: ~~12/11~~05/15
Medical Executive Committee Approval: ~~01/12~~06/15
Professional Affairs Committee Approval: ~~02/12~~07/15
Board of Directors Approval: 02/12

A. **PURPOSE:**
1. To provide a consistent standardized organizational-wide policy for the use of violent/self-destructive behavior restraint and/or seclusion.

B. **PHILOSOPHY:**
1. Tri-City Healthcare District acknowledges restraint may be necessary for certain patient populations. Restraint or seclusion is limited to emergencies in which there is an imminent risk of patient physically harming himself/herself, or others, and nonphysical interventions would not be effective.
2. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event seclusion or restraint of a patient becomes necessary, **Tri-City Medical Center (TCMC)** supports a philosophy, which will protect the patient's health and safety and preserves his/her dignity, rights and well-being. Restraints of any type should not be used as a punishment, retaliation, coercion, or for the convenience of staff, and should be discontinued as soon as possible. All patients are given information regarding patients' rights upon admission.
3. The type of physical intervention selected considers information learned from the patient's initial assessment, which outlines interventions that have helped him/her in crisis situations in the past which could minimize the use of restraint or seclusion. The use of restraint or seclusion is not based on a patient's restraint or seclusion history or solely on history of dangerous behavior.

C. **DEFINITIONS:**
1. Restraint – Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.
   a. Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to movie his/her arms, legs, body, or head freely.
   b. Chemical Restraint: A drug or medication used as a restriction to manage the patient's violent/aggressive behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A PRN order does not determine the use of that drug as a restraint. Criteria for "standard treatment or dosage" are treating a specific patient's clinical condition of symptoms, not behaviors, which enable the patient to function more effective and appropriately (not a restraint) rather than reduce that patient's ability to interact with the world around them (restraint).
      i. Emergency Medication: It may be necessary to use psychotropic agents to control severe agitation. Medications ordered and taken voluntarily on a PRN basis as indicated for the psychiatric condition being treated are not considered

chemical restraint. Emergency medication given against a patient's will is not considered a chemical restraint if it is for the treatment of acute symptoms of a psychiatric illness.

2. Seclusion – The involuntary confinement of a patient *alone* in a room or area from which the patient is physically prevented from leaving. Seclusion is a form of restraint that may be used only for the management of violent or self destructive behavior.
3. Time-out - A strategy which directs patient from the general milieu to a quiet area to provide a less stimulating environment. A responsible RN implements time-out based on assessed need when time-out is documented as an intervention on the patient's plan of care. Time-out is voluntary; it is designed as a least restrictive behavior management technique. Time-out becomes a form of physical restraint if the patient is prevented from leaving the time-out area.
4. Physical Escort – A physical escort would include a "light" grasp to **guide**~~escort~~ the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
5. Physical Holds – The regulation permits the physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients do have the right to refuse treatment. This includes the right to refuse physical examinations or tests. ~~Holding a patient in a manner that restricts the patient's movement against the patient's will is considered restraint.~~**Holding a patient for being violent or self destructive or to force psychotropic medications is considered restraint, but if patient consents to injection then it is permitted to hold patient if patient allows.**
6. ~~Licensed Independent Practitioner (LIP) – An individual permitted by State law and by the hospital to order restraints and seclusion for patients independently, within the scope of the individual's license and consistent with individually granted clinical privileges. Physicians and other LIPs authorized to order restraint or seclusion will have a working knowledge of this policy.~~
7. **Practitioner – any physician, dentist, or podiatrist who is ~~applying for Medical Staff membership and/or clinical privileges or who is~~ a Medical Staff member and/or who exercises clinical privileges at TCMC as context requires, unless otherwise expressly limited.**
8. Qualified/Specially Trained Staff – Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served. The Qualified/Specially trained RN has additional training and demonstrates competency in the First Hour assessment and documentation process.

D. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are not considered restraint:
   a. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure (i.e., surgical positioning, IV arm boards, papoose, protection of surgical and treatment sites in pediatric patients).
   b. Adaptive support in response to assessed patient needs (i.e., orthopedic prescribed devices, postural support, table top chairs).
   c. Protective equipment such as helmets.
   d. Hand mitts (gloves only) to keep from scratching self (if pinning wrists down with mitts, hand or fingers are immobilized, this is considered a restraint).
   e. Devices that permit the patient to participate in activities without the risk of physical harm.

f. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes (i.e., handcuffs, shackles).
g. Restraint use for non-violent/non-self-destructive behavior to which the restraint standards for non-violent/non-self-destructive behavior apply.

E. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room that is not under continuous observation by staff is at greater risk for self – injury or adverse occurrences.

F. **ORDERS:**

1. All restraint and seclusion are applied and continued pursuant to an order by the **practitioner**~~Medical Doctor (MD)/ Licensed Independent Practitioner (LIP)~~ who is primarily responsible for the patient's ongoing care, or his or her designee.
2. In the case of emergency, a patient may be placed in restraint/seclusion at the discretion of the Registered Nurse (RN)
3. As soon as possible but no longer than one hour after the initiation of restraint or seclusion by a RN, he or she:
   a. Notifies and obtains an order (**telephone** ~~verbal~~ or written) from the **practitioner**~~MD/LIP~~
   b. Consults with the **practitioner**~~MD/LIP~~ about the patient's physical and psychological condition
   c. Supplies staff with guidance in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued as soon as safely possible.
4. The **practitioner**~~MD/LIP~~ does the following:
   a. Reviews with the staff the physical and psychological status of the patient
   b. Determines whether restraint or seclusion should be continued
5. ~~Verbal~~ **Telephone** and written orders for restraint and seclusion are limited to the following:
   a. 4 hours for patients ages 18 and older
   b. 2 hours for children and youth ages 9 to 17
   c. 1 hour for children under age 9
6. Orders for restraint or seclusion are not written as a standing order or on an as needed basis (that is, PRN).
7. When restraint or seclusion is terminated before the time-limited order expires, the original order cannot be used to reapply the restraint or seclusion if the patient is at imminent risk or physically harming themselves or others, and non-physical interventions are not effective.
   a. Each application of restraint must be considered a separate episode in which all assessment and documentation procedures are applied.
8. If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the **practitioner**~~MD/LIP~~ primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee.
9. Orders for violent/self-destructive restraint and/or seclusion must include: restraint and/or seclusion start and end time, action justifying restraint, type of restraint, criteria for release, contributing diagnosis and new medications.

G. **INITIATION/DOCUMENTATION:**

1. The **practitioner**~~MD/LIP~~ primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee or a qualified/specially trained RN or Physician's Assistant (PA), evaluates the patient in person within 1 hour of the initiation of restraint or seclusion.
2. At the time of the in-person evaluation, the **practitioner**~~MD/LIP~~/RN**/PA** does the following:
   a. Works with the patient and staff to identify ways to help the patient regain control
   b. Revises the patient's plan of care, treatment, and services as needed
      i. If necessary, the **practitioner**~~MD/LIP~~ provides a new written order and documents
      ii. The immediate situation
      iii. The patient's reaction to the intervention
      iv. The patient's medical and behavioral condition
      v. The need to continue or discontinue the restraint or seclusion.
3. If the First hour face-to-face evaluation is conducted by a qualified/specially trained RN or PA, the attending **practitioner**~~physician or other LIP~~ who is responsible for the care of the patient shall be consulted ~~as soon as possible after completion of the evaluation and must conduct and in-person evaluation within 4 hours of the initiation of the event.~~**within one hour after completion of the evaluation.**
   a. Another one-hour face-to-face patient evaluation is not required when the original order is renewed.
4. When the use of violent/self-destructive restraints occurs in the other acute inpatient areas, after handling the immediate situation, the staff shall consult with the Behavioral Health Unit staff. A qualified/specially trained RN shall assist the acute inpatient staff to ensure that safety procedures, monitoring tools and notifications occur per policy.
5. Alternatives and nonphysical interventions including redirecting the patient's focus or employing verbal de-escalation should be attempted prior to initiating restraints/seclusion. Refer to examples of alternative interventions on Appendix A.
6. If alternatives and non-physical interventions are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
7. The RN is responsible for assessing the patient before restraint use is initiated.
8. The RN shall document initiation of restraint **in the medical record on the appropriate restraint electronic form or paper restraint flowsheet. The following shall be documented:**
   a. Restraint reason i.e., Violent/Self Destructive Behavior Restraint
   b. Restraint Initiation Date and Time
   c. Type of Restraint: Locked device/Hard Restraints, Physical Hold
   d. Restraint Location: i.e. left or right upper or lower extremity
   e. Action justifying use of Restraint
   f. Description of other behavior requiring restraint
   g. Pre-restraint alternatives attempted
   h. Effectiveness of Pre-restraint alternatives
   i. Education provided to patient/family education
   j. Patient's rights denied~~on Restraint Violent Behavior Initiation Powerform or 24 hour behavioral restraint flowsheet including: restraint type, location, contributing diagnosis, time initiated, behavior necessitating the use of restraints, description of other behavior requiring restraint/seclusion, pre-restraint alternatives attempted, and patient/family education~~.

H. **ONGOING MONITORING/DOCUMENTATION:**

1. **Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:**
   a. 4 hours for adults 18 years of age or older;
   b. 2 hours for children and adolescents 9 to 17 years of age; or
   c. 1 hour for children under 9 years of age

2. **If a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the practitioner~~physician or other LIP~~ who is responsible for the care of the patient must conduct a face-to-face patient evaluation before writing a new order for the continued use of restraint or seclusion.**

~~2.Before the order for restraint or seclusion expires, the patient shall be evaluated in person by the MD/LIP primarily responsible for the patient's ongoing care or his or her designee or a qualified, trained individual authorized by the hospital to perform this function.~~

~~3.The patient shall be reevaluated every 4 hours for adults ages 18 and older, every 2 hours for children and youth ages 9 to 17 and every hour for children under age 9 including:~~
~~a.A new written or verbal order shall be initiated if the restraint or seclusion is to be continued~~
~~b.The efficacy of the patient's treatment plan shall be reviewed~~
~~c.~~**a.** ~~The patient shall be assisted to identify ways to gain control so the intervention can be discontinued.~~

~~3. The MD/LIP conducts an in-person reevaluation at least every 8 hours for patients 18 years or older and every 4 hours for patients ages 17 and younger.~~

~~5.~~**3.** If the patient's **practitioner**~~MD/LIP~~, or his or her designee, is not the **practitioner**~~MD/LIP~~ who gives the order, the patient's **practitioner**~~MD/LIP~~ is notified of the patient's status if the restraint or seclusion is continued.

~~6.~~**4.** Patients in restraint and seclusion shall be monitored continuously by in-person observation by an assigned staff member who is competent and trained.

~~7.~~**5.** An individual in <u>seclusion without restraints</u> may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition or wishes.

~~8.~~**6.** A trained and competent RN assesses the patient every 15 minutes while the patient is in restraint or seclusion for signs of any injury associated with applying restraint or seclusion, nutrition and hydration, skin/circulation and range of motion in extremities **(release one restraint at a time, beginning with the ankles)**, hygiene and elimination, physical and psychological status and comfort and readiness for discontinuation of restraint **to ensure the release at the earliest possible time**. Vital signs will be monitored every ~~one hour~~**15 minutes**, or as clinically indicated. The RN documents the assessment **in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.** ~~on the Restraint Violent Behavior Monitoring Powerform or 24 hour behavioral restraint flowsheet.~~

7. **In some cases, vital signs taken every 15 minutes may be excessive or disruptive to patient care. Document a valid rationale for the decision regarding vital signs not assessed every 15 minutes.**

8. The staff helps patients meet behavioral criteria for discontinuing restraint or seclusion.

~~9.The sleeping patient shall be assessed every 15 minutes as appropriate to the patient's condition, needs and the type of restraint or seclusion. Clinical judgment and knowledge of the patient and his or her individual needs shall be used to determine when and what items need to be evaluated.~~

I. **<u>DEBRIEFING:</u>**

1. The patient and, if appropriate, the patient's family shall participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion. The debriefing shall:
   a. Occur as soon as possible and appropriate but no longer than 24 hours after the episode.
   b. Identify what led to the incident and what could have been handled differently.
   c. Ascertain that the patient's physical well being, psychological comfort, and right to privacy were addressed.
   d. Counsel the patient for any trauma that may have resulted from the incident.
   e. Result in modification of the patient's plan of care, treatment, and services if indicated.

J. **<u>COMPETENCY AND EDUCATION:</u>**

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the **application and monitoring** ~~use~~ of behavioral restraint/seclusion, and shall undergo education and training in the proper and safe use of restraint/seclusion during initial orientation and annually thereafter.

~~1.~~**2.** Training requirements include but are not limited to:

a. The determination of who has authority to order restraint and seclusion
b. The determination of who has authority to discontinue the use of restraint or seclusion
c. The determination of who can initiate the use of restraint or seclusion
d. The circumstances under which restraint or seclusion is discontinued
e. The requirement that restraint or seclusion is discontinued
f. A definition of restraint
g. A definition of seclusion
h. A definition or description of what constitutes the use of medications as a restraint
i. A determination of who can assess and monitor patients in restraints or seclusion
j. Time frames for assessing and monitoring patients in restraints or seclusion

~~2.~~**3.** Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring process of restraint or seclusion. In addition, there shall be a qualified staff member assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure that the proper safety procedures, orders and monitoring are implemented.

~~3.~~**4.** **Practitioners**~~Physicians and LIPs~~ shall be educated in the use of restraint.

~~4.~~**5.** Qualified/specially trained RN shall undergo education and training regarding the First Hour Assessment and demonstrate annual competency.

K. **STAFFING:**

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, concurrent conditions, patient acuity, age, and developmental functioning of the patient. These elements shall be addressed in the staffing mix of the unit.

L. **DISCONTINUATION/DOCUMENTATION:**

1. As early as feasible in the restraint or seclusion process, the patient is made aware of the rationale for restraint or seclusion and the behavioral criteria for discontinuation.
2. When the patient meets his or her behavioral criteria for restraint discontinuation, all four restraints shall be released at the same time.
3. Restraint or seclusion is discontinued as soon as the patient meets his or her behavioral criteria. ~~and documented on the Restraint Violent Behavior Monitoring Powerform or 24 hour restraint flowsheet~~
4. **Document discontinuation of restraint in the medical record on the appropriate restraint electronic form or paper restraint flowsheet**.

~~3.~~**5.** **Document patient's rights restored**

M. **PATIENT/FAMILY EDUCATION:**

1. The following education shall be provided to the patient and his/her family (with patient consent):
   a. Clinical reason for restraint
   b. Purpose and use of restraint
   c. Monitoring and care that shall be provided to patient
   d. Criteria necessary for termination of restraint
   e. Any other information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. In cases in which the patient has consented to have the family kept informed about his or her care, treatment, and services and the family has agreed to be notified, staff attempts to contact the family promptly to notify them of the restraint or seclusion episode.

N. **PLAN OF CARE:**

1. The plan of care will be modified according to the use and discontinuation of restraints.

O. **NOTIFICATION:**

1. The hospital shall report **required information** to Center**s for** ~~of~~ Medicare **and** /Medicaid Services (CMS) per regulations. **See the examples below:**
   - **a. Each death that occurs while a patient is in restraint or seclusion**
   - **b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.**
   - **c. Each death known to the hospital that occurs within one week after restraint or seclusion was used.**
2. Regulatory Compliance shall document in the patient's medical record the date and time the death was reported to CMS.

~~iv.~~**P. PERFORMANCE IMPROVEMENT:**

1. Data shall be collected on all occurrences of restraints **and** /seclusion and submitted **to the Restraint Committee and reviewed by the Joint Commission Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement**

~~1.~~**2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint use.** ~~quarterly to an appropriate council/committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance~~ improvement.

~~*a.The processes or events that shall be monitored, in particular include:*~~

~~*i.Multiple instances of restraint or seclusion experienced by a patient within twelve (12) hour period*~~

~~*ii.The number of episodes per patient*~~

~~*iii.Instances that exceed twelve (12) consecutive hours*~~

~~*iv.Use of psychoactive medications as an alternative for or to enable discontinuation of restraint or seclusion*~~

~~*v.Oversight of restraint and seclusion use throughout the hospital by qualified L.I.P.s.*~~

~~*2.Information obtained and documented from the debriefings shall be used in performance improvement activities.*~~

~~3.The following Data on all restraint and seclusion episodes are collected quarterly and submitted to Patient CareRestraint Committee and reported to Joint Commission Committee Quarterly to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities to performance improvement: check with Priscilla~~

~~a.Shift~~

~~b.Staff who initiated the process~~

~~c.The length of the episode~~

~~d.Date and time each episode was initiated~~

~~e.The type of restraint used~~

~~f.Whether injuries were sustained by the patient or staff~~

~~g.Age of the patient~~

~~h.Gender of the patient~~

~~i.Debriefing data~~

~~P.~~**Q. REFERENCES:**

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

~~1. Comprehensive Accreditation Manual for Behavioral Health Care, 2009~~
~~2.CMS 482.13E~~
~~3.Federal Registry Part IV Department of Health and Human Services: CMS 42CFR Part 482, 2009.~~
~~4.Hospital Accreditation Standards. 2010. http://www.jointcommission.org~~
~~5.California Title 22 Standards. Psychiatric Unit General Requirements: 70577.~~

Restraint Education/ Competency Based Upon Scope of Practice

Restraints for ~~Non~~-Violent/~~Non~~-Self-Destructive Behavior						
	Registered Nurse	CNA/ NA ACT/MHW/~~RTET~~	Security	Behavioral Health Liaison	**Qualified/specially trained RN**~~BHU Assistant Nurse Manager/Charge Nurse~~	Regulatory
Pre-Restraint Alternatives~~Initiation~~	✓	✓			✓	
Initiation	✓				✓	
Orders	✓				✓	
~~Pre-Restraint Alternatives~~	~~✓~~	~~✓~~				
Ongoing Monitoring	✓	✓			✓	
Observation	✓	✓	✓	✓	✓	
Patient Care	✓	✓			✓	
Vital Signs	✓	✓			✓	
Assessment/Reassessment	✓				✓	
Discontinuation	✓				✓	
Documentation **(PIRP, Careplan)**	✓				✓	
Release and/or Re-secure	✓	✓	✓		✓	
~~Handle immediate situation~~	~~✓~~	~~✓~~	~~✓~~			
~~Call Behavioral Health for assistance in requirements~~	~~✓~~					
Complete 1 hour face-to-face evaluation					✓	
Debriefing	✓		✓	✓	✓	
Report restraint related death to CMS						✓
Document CMS notification in Patient's medical record						✓

✓= Required for scope of practice

APPENDIX A: ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives

- Diversion activities such as: TV, soothing music, books, or folding washcloths
- Family interaction
- Orientation to day, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values

- Pharmacy consult

Tri-City Medical Center	Women's & Children's Services Manual - NICU
PROCEDURE:	**CAR SEAT CHALLENGE TEST**
Purpose:	To assess premature, low birth weight and compromised infants positioning in a car seat without evidence of respiratory compromise prior to discharge.
Supportive Data:	The infant's head is proportionally large relative to the rest of the body; the straight back of the car seat may flex the neck excessively, increasing the risk of hypoxia.
Equipment:	1. Patient's car seat 2. Car seat base 3. Cardio-respiratory monitor 4. Pulse oximeter 5. Pulse oximeter patient probe 6. Blanket rolls
~~Issue Date: 9/07~~	~~Revision Date: 12/09, 6/11, 8/12~~

A. **POLICY:**

1. In accordance with the American Academy of Pediatrics (AAP) recommendations, all patients meeting one of the following criteria at the time of discharge should receive a positional car seat challenge test:
   a. Gestational age is less than 37 weeks at the time of birth.
   b. Low birth weight patients weighing less than 2,500 gm.
   c. Patients with a medical condition that places them at risk for apnea or oxygen desaturation.
   d. Other patients at discretion of physician/**Allied Health Professional**~~**licensed independent practitioner (LIP)**~~, (i.e., supplemental oxygen at discharge or oxygen within one week of discharge).
2. According to AAP/**National Association of Neonatal Nurses (**NANN**)** guidelines, car seat challenge tests are to be completed 2 to 4 days prior to discharge/7 days maximum.

B. **PROCEDURE:**

1. Verify physician/**Allied Health Professional**~~**LIP**~~'s order for car seat challenge test.
   a. A car seat challenge test on a patient with an NG tube is applicable only if the patient is being discharged home with NG tube.
   b. Recommendation is to wait until the NG tube is discontinued prior to proceeding with testing.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services "Identification, Patient" ~~(IV.A)~~ policy
3. Place the car seat in the car seat base on a stable surface.
   a. Shall be conducted in the car safety seat intended for regular use by that particular patient.
4. Place the patient in the car seat with buttocks and back flat against the back of the car seat.
   a. Blanket rolls may be placed on both sides of the patient for lateral support of the head and neck
   b. To keep the patient from slouching, pad the sides of the seat and between the legs with rolled diapers or receiving blankets, provided by parents.
   c. Nothing should be placed under or behind the patient
5. Position the car seat retainer clip on the patient's chest.
6. Ensure that the patient is reclined to a 45° angle when positioned in the car seat to prevent the patient's head from dropping forward.
7. Place the patient on a cardio respiratory monitor, pulse oximeter monitor, and observe for ~~60~~**90** minutes or longer if the predicted car ride home is longer, while positioned in the car seat.

Department Review	Division of Neonatology	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
01/15	01/15	04/15	n/a	05/15	07/15	09/07, 12/09, 6/11, 8/12

a. Do not leave the patient unattended at any time
b. Test should be done in between feedings

8. Record the patient's baseline heart rate, respiratory rate, oxygen saturation, and assessment parameters when first positioned in the car seat and every 15 minutes thereafter for the duration of the test.
   a. The values recorded should be taken from the monitor readings.
9. Visually assess the patient's skin color, respiratory effort and activity level.
   a. Record observations when patient is first positioned in the car seat and every 15 minutes thereafter
9. Record the patient's diagnoses, age, weight, medication regime and time of last feeding. Indicate whether oxygen is in use.
   a. Encourage the parents to take the car seat home at the conclusion of the study, or the following day
10. The testing should be discontinued immediately and considered failed if the patient experiences:
   a. Bradycardia below 80 bpm or a heart rate drop of 30 beats below baseline for 20 seconds or longer
   b. Apnea (lack of respirations for 20 seconds or longer)
   c. Persistent labored respirations
   d. Dusky-colored skin accompanied by pulse oximetry readings of less than 90% for 10 seconds or longer
11. In the event of apnea, bradycardia or oxygen desaturation, clinically stimulate the patient, reposition, administer oxygen and perform other appropriate interventions.
   a. Document actions in the patient's medical record.
12. Terminate the test if symptoms persist.
   a. Document whether the patient has passed or failed the test in the patient's medical record.
   b. Notify the ~~physician~~**/Allied Health Professional**~~LIP~~ if the patient fails the test, including the assessment values.
13. Remove the patient from the car seat at the end of testing and resume routine care.
14. Unless there is a definitive change in the patient's condition or stability, a successful test does not need to be repeated, even if the discharge date is extended.
15. If failed first test repeat test in 12-24 hours.
16. If the patient fails the test a second time, the patient can be discharged in a car bed following a discussion with the attending physician**/Allied Health Professional**~~LIP~~.
17. Inform the parents that the patient should be transported in a car bed until he reaches 20 lb.
18. The ~~physician~~**/Allied Health Professional**~~LIP~~ should educate parents about restrictions on related activities (e.g., swings in which upright sitting positions are required).
19. Place the completed flow sheet in the patient's medical record at the bedside.

C. **MOTHER-BABY/NURSERY SPECIAL CONSIDERATIONS:**

1. Recommendations for **Failed** car seat challenge tests (CSCT) performed on late preterm patients admitted to the Mother-Baby unit:
   a. Notify pediatrician of failed car seat challenge test.
   b. Notify Neonatologist**/Allied Health Professional**~~LIP~~ if pediatrician is unavailable or not able to see patient within 30 minutes
   c. Transfer patient to boarder status in the newborn nursery.
   d. Place cardio-respiratory (CR) monitor on patient for continuous monitoring of SpO2, respiratory rate, and heart rate.
   e. Notify pediatrician for any concerns or issues while patient on (CR) monitoring requiring further and timely examination.

D. **REFERENCES:**

1. American Academy of Pediatrics (AAP), Bull, M.J., Engle, W.A. (2009). *Safe Transportation of Preterm and Low Birth Weight Infants at Hospital Discharge.* Pediatrics: 123, 5.

2. Besuner, P. (2007). AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Association of Women's Health, Obstetric and Neonatal Nurses: *Positional Apnea Car Seat Assessment*. Washington, D.C.
3. **Ikuta, L.M. & Beauman, S.S. (2011). *Policies and procedures, and competencies for neonatal nursing care.* Glenview, IL: National Association of Neonatal Nurses**

DELETE - eliminate WNS procedure and utilize NICU procedure

Tri-City Medical Center

Distribution: Women & Newborn Services

PROCEDURE:	CAR SEAT CHALLENGE TEST
Purpose:	To assess premature, low birth weight and compromised infants positioning in a car seat without evidence of respiratory compromise prior to discharge.
Supportive Data:	The infant's head is proportionally large relative to the rest of the body; the straight back of the car seat may flex the neck excessively, increasing the risk of hypoxia.
Equipment:	1. Infant car seat 2. Car seat base 3. Cardio-respiratory monitor 4. Pulse oximeter 5. Pulse oximeter patient probe 6. Blanket rolls 7. Car Seat Challenge flow sheet

POLICY:

A.

1. In accordance with the American Academy of Pediatrics (AAP) recommendations, all infants meeting one of the following criteria at the time of discharge should receive a positional car seat challenge test:
   a. Gestational age is less than 37 weeks at the time of birth.
   b. Low birth weight infants weighing less than 2,500g.
   c. Other infants only at discretion of physician, (i.e., supplemental oxygen at discharge or oxygen within one week of discharge).
   d. Infants with a medical condition that places them at risk for apnea or oxygen desaturation.
2. According to AAP/NANN guidelines, car seat challenges are to be completed 2 to 4 days prior to discharge/7 days maximum.

B. **PROCEDURE:**

1. Verify physician's order for Car seat challenge test.
   a. A car seat challenge on a baby with an NG tube is applicable if the baby is going home with one.
      i. Recommendation is to wait until the NG tube comes out before proceeding with testing
2. Place the car seat in the car seat base on a stable surface.
   a. The observation should last a minimum of 60 minutes or the duration of travel, whichever is longer, and
   b. Shall be conducted in the car safety seat intended for regular use by that particular infant.
   c. The brand of car seat should be recorded on the positional car seat test flow sheet. (Refer to attachment "Car Seat Challenge Flow Sheet")
   d. The flow sheet shall be used to record patient data, which shall be collected and recorded by an RN
3. Place the infant in the car seat with buttocks and back flat against the back of the car seat.
   a. Blanket rolls may be placed on both sides of the infant for lateral support of the head and neck
   b. To keep the infant from slouching, pad the sides of the seat and between the legs with rolled diapers or receiving blankets (remind parents to bring in 4 four receiving blankets and a washcloth)
   c. Nothing should be placed under or behind the infant

Review/Revision Date	Clinical Policies & Procedures	Patient Care Quality Committee	Medical Department Review	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
6/07, 05/08, 7/09	7/07	8/07	8/07, 9/09, 3/15	8/07, 5/15	9/07, 07/15	9/07, 12/09

4. Position the car seat retainer clip on the infant's chest.
5. Ensure that the infant is reclined to a 45° angle when positioned in the car seat to prevent the infant's head from dropping forward.
6. Place the infant on a cardio-respiratory monitor, pulse oximeter monitor, and observe for 60 minutes or longer if the predicted car ride home is longer, while positioned in the car seat.
    a. Do not leave the infant unattended at any time
    b. Test should be done in between feedings
7. Record the infant's baseline heart rate, respiratory rate, oxygen saturation, and assessment parameters when first positioned in the car seat and every 15 minutes thereafter for the duration of the test.
    a. The values recorded should be taken from the monitor readings
8. Visually assess the infant's skin color, respiratory effort and activity level.
    a. Record observations when infant is first positioned in car seat and every 15 minutes thereafter
    b. Place a check mark in the appropriate patient parameter box
11. Record the infant's diagnoses, age, weight, medication regime and time of last feeding on the flow sheet. Indicate whether oxygen is in use.
    a. Return infant to the crib at the conclusion of the study
    b. Encourage the parents to take the car seat home at the conclusion of the study, or the following day
12. The testing should be discontinued immediately and considered failed if the infant experiences:
    a. Bradycardia below 80 bpm or a heart rate drop of 30 beats below baseline for 20s or longer
    b. Apnea (lack of respirations for 20 s or longer)
    c. Persistent labored respirations
    d. Dusky-colored skin accompanied by pulse oximetry readings of less than 90% for 10 seconds or longer
13. In the event of apnea, bradycardia or oxygen desaturation, clinically stimulate the infant, reposition, administer oxygen and perform other appropriate interventions.
    a. Document actions on the flow sheet under Interventions and place it in the infant's chart
14. Terminate the test if symptoms persist.
    a. Indicate with a check mark whether the infant has passed or failed the test and sign the flow sheet
    b. Notify the physician that the infant has failed the test, including the assessment values
15. Remove the infant from the car seat at the end of testing and resume routine care.
16. Unless there is a definitive change in the patient's condition or stability, a successful test does not need to be repeated, even if the discharge date is extended.
17. Repeat test if failed first trial in 12-24 hours.
18. If the infant fails the test a second time, the patient can be discharged in a car bed following a discussion with the attending physician.
19. Inform the parents that the infant should be transported in a car bed until he reaches 20 lb.
20. The physician should educate parents about restrictions on related activities (e.g., swings in which upright sitting positions are required).
21. Place the completed flow sheet in the patient's medical record at the bedside.

C. **MOTHER-BABY/NURSERY SPECIAL CONSIDERATIONS:**

1. Recommendations for **Failed** car seat challenge tests (CSCT) performed on late preterm (near term) infants admitted to the Mother-Baby unit:
    a. Notify pediatrician of failed car seat challenge test.
    b. Transfer infant to border status in the newborn nursery.
    c. Place cardio-respiratory (CR) monitor on infant for continuous monitoring of SpO2, respiratory rate, and heart rate.
    d. Notify pediatrician for concerns or issues while infant on (CR) monitoring requiring further and timely examination.
    e. If infant fails the CSCT for any of the reasons below, notify the pediatrician immediately:

i. Episodes of apnea
ii. SpO2 < 85%
iii. HR of less than 80 bpm
iv. Notify Neonatologist if pediatrician is unavailable or not able to see infant within 30 minutes

D. **REFERENCES:**

1. American Academy of Pediatrics (AAP), Bull, M.J., Engle, W.A. (2009, May). *Safe Transportation of Preterm and Low Birth Weight Infants at Hospital Discharge.* Pediatrics: 123,5
2. Besuner, P. (2007). AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Association of Women's Health, Obstetric and Neonatal Nurses: *Positional Apnea Car Seat Assessment.* Washington, D.C

Car Seat Challenge Flow Sheet

Date: _____ Passed: _____ Failed: _____

Time: _____

Car Seat Brand/Model: _____

Patient Diagnosis: _____

Gestational Age at time of Car Seat Challenge: _____

Birth weight: _____ Present Weight: _____

Time of Last Feed: _____

Oxygen in Use: _____

Medications: _____

Car Seat Information Sheet given to Parent: Date: _____ RN Initials: _____

Patient Parameter	Baseline	15 min.	30 min.	45 min.	60 min.
Heart Rate					
Respiratory Rate					
Color					
O_2 Saturation					
Asleep					
Quiet/Awake					
Crying					
Angle of Car Seat					

Comments:

Problems/Interventions:

RN Signature: _____

Form # 6070-1011

Tri-City Medical Center
Oceanside, California

Emergency Operations Procedure Manual
Special Circumstances

SUBJECT: **CODE SILVER Person with Weapon or Active Shooter**

ISSUE DATE: **NEW**
REVIEW DATE(S):
REVISION DATE(S):

Department Approval Date(s):	**06/15**
Environmental Health and Safety Committee Approval Dates(s):	**07/15**
Medical Executive Committee Approval Dates(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**07/15**
Board of Directors Approval Date(s):	

A. POLICY:

1. To assure a timely response to situations involving an actual or potential physical threat to patients, volunteers, students, physicians, employees, visitors or property. It is the policy of the hospital to take all reasonable measures to minimize the negative impacts of a situation involving a person with a weapon, an active shooter or a hostage situation.

B. PURPOSE:

1. To provide an appropriate response in the event of an incident involving a person with a weapon, an active shooter or a hostage situation within the facility.

C. PROCEDURE:

1. Discovery:
   - a. Anyone encountering a person brandishing a weapon should:
     - i. Seek cover and warn others of the situation.
     - ii. Clear immediate danger area of all personnel.
     - iii. Staff is to call "66" with all known information.
       1) Location – department, area, or room number.
       2) Suspects – number and any physical descriptions.
       3) Any known hostages or victims.
       4) Any relevant information (weapons, demands)
       5) Law enforcement personnel authorized to carry a weapon should be identified if they are not in a distinctive uniform.
   - b. Private Branch Exchange (PBX) Operator will:
     - i. Immediately initiate Active Shooter procedures specifying the location within the facility.
     - ii. The PBX operator will announce via the overhead system "Code Silver" three (3) times twice along with location of the situation.
     - iii. Due to the nature of the incident, the PBX operator will also notify law enforcement by calling 9-1-1.
2. Response (Code Silver):
   - a. Any staff members in the location affected by the Code Silver should:
     - i. Evacuate if possible.
     - ii. Seek cover/protection and warn others of the situation.
     - iii. Do not panic and stay alert. Remain calm.
     - iv. Do not make contact with the shooter(s).

b. Any staff members not in the area of the Code Silver should:
   i. Upon hearing the overhead announcement of a Code Silver, stay away from the location stated.
   ii. Close all patient and unit exit doors.
   iii. Take cover and barricade yourself behind locked doors.
   iv. Provide assistance as requested by an authorized person.

3. Triage Response:
   a. Wait for law enforcement to declare the scene "safe for triage" before any clinical personnel enter to triage patients / victims.
   b. If staff or physicians MUST enter or leave the building or a patient has an emergency that requires movement, law enforcement must be notified. If appropriate, an armed escort by law enforcement should be provided.
4. Hospital Command Center:
   a. The administrator-on-call (AOC) or Administrative Supervisor will assume the role of Incident Commander or delegate the responsibility to the most qualified individual.
   b. The Incident Commander will activate the Command Center (CC) in an area not affected by the situation.
   c. The Incident Commander will activate those positions within Hospital Incident Command System (HICS) that is necessary as the situation determines.
   d. All incoming patients should be diverted to other nearby healthcare facilities. Those facilities must be notified regarding the Code Silver situation.
5. Law Enforcement Arrival:
   a. When law enforcement arrives, it will become their incident and they will assume full responsibility of managing the situation. All staff is requested to cooperate fully with law enforcement.
   b. Law enforcement will need a copy of the facility's floor plans, indicating rooms, exits, windows, utility access, keys and access badges.
   c. Law enforcement will establish their separate incident command post outside the facility and away from the situation.
   d. Victim response:
      i. Show hands at all time when law enforcement arrives on scene
      ii. Follow law enforcement instructions as they are given
      iii. Verbally identify yourself
      iv. Advise law enforcement if you are injured and require medical attention
      v. Leave all personal belongings during the evacuation process.
6. Media:
   a. The Public Information Officer (PIO) will contact families of identified hostages and serve as the liaison with the media.
   b. All media coverage is to be directed to the Public Information Officer and facility staff will not give out information to the media. Protection of privacy is extremely important and staff should not be discussing the situation openly. All official statements by the facility will be discussed with the designated law enforcement representative before being released.
7. All Clear:
   a. The Incident Commander, after consultation with law enforcement, shall issue an "All Clear" notification to the PBX Operator to indicate termination of the situation.
   b. The PBX Operator will announce "Code Silver All Clear" three (3) times via the overhead announcement system.
   c. All facility staff may return to their departments and normal operations at this time if permitted.
8. After-Action:
   a. Be prepared to spend considerable time with law enforcement reviewing the situation in detail.
   b. Facility administrators and staff must meet after the conclusion of the incident within a 24-48 hour time frame to review the situation from start to finish.

c. The goal of the debriefing is not to determine fault but, what actions, policies and procedures could be enhanced to better respond in a Code Silver situation.

9. Mental Health Considerations:
   a. It is strongly recommended that all affected persons in the Code Silver situation be required to complete an initial mental health evaluation by a professional to determine if continued therapy is required and for what duration the therapy is to continue. All persons involved in the situation should be provided a written evaluation with the mental health professional's recommendation for a return to duty date.

D. EDUCATION AND TRAINING:

1. Training and education to ensure that all staff of Tri-City ~~Medical Center~~**Healthcare District (TCHD)** is aware of potential security hazards and how to protect themselves, co-workers and guests through established policies and procedures.
2. Training for staff must include what to do if they become a hostage or victim.
3. Employees at all **TCHD** ~~Tri-City Medical Center~~ off site buildings will call 911 first and inform the local law enforcement agency of the situation.

E. REFERENCES:

1. California Hospital Association / Active Shooter Guide
2. U.S. Department of Homeland Security "How to respond when an Active Shooter is in your vicinity".

Tri-City Health Care District
Oceanside, California

PHARMACY MANUAL~~POLICY~~

ISSUE DATE:	**11/11**	**SUBJECT:**	**Chemotherapy, Prescribing, Processing, and Preparation**
REVISION DATE:	**05/2013, ~~3/15~~**	**~~POLICY NUMBER: 8390-4204~~**	
Department Approval Date(s):		**03/15**	
Pharmacy and Therapeutics Committee Approval:		**3/20/12; 3/14; 03/15**	
Medical Executive Committee Approval:		**3/26/12; 05/14; 06/15**	
Professional Affairs Committee Approval:		**06/14, 07/15**	
Board of Directors Approval:		**3/30/12, 6/14**	

A. **PURPOSE:**

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

B. **CHEMOTHERAPY PRESCRIBING POLICY:**

1. Chemotherapy will encompass all anti-neoplastic agents used to treat cancer including monoclonal antibodies, oral tyrosine kinase inhibitors as well as traditional cytotoxic chemotherapy.

~~1.~~**2.** Orders written for chemotherapy agents shall meet the following criteria:

a. Written on the standard pre-printed "Chemotherapy Order Form"
   i. Telephone and verbal orders between physicians and physician assistant/nursing will not be accepted unless to hold or stop chemotherapy administration.
   ii. Changes to orders regarding drug, dosing parameters, route, diagnosis, or patient name/2nd identifiers will only be accepted by pharmacy if re-written by the physician on the Chemotherapy Order Form or template.
   iii. A pharmacist may change the order with "verbal order read back" regarding the dose, infusion time, height/weight, dates of therapy.
   iv. Corrected carboplatin doses based on AUC and CrCl may be calculated by the pharmacist and documented on the original order by the pharmacist. The pharmacist must read back the change from the actual written transcription to the physician.
   v. New orders or changes to orders must be documented in the electronic medical record (if applicable).

b. Complete orders must include:
   i. Patient's full name and second patient identifier (medical record number, DOB)
   ii. Date
   iii. Diagnosis
   iv. Regimen name and cycle number
   v. Protocol name and number (if applicable)
   vi. Appropriate criteria to treat (i.e based on relevant laboratory results and toxicities)
   vii. Allergies
   viii. Reference to the methodology of the dose calculation or standard of practice equations (i.e calculation of creatinine clearance)
   ix. Height, weight and any other variables used to calculate the dose (i.e BSA)
   x. Dosage
      1) Doses may not include trailing zeros; use a leading zero for doses less than 1 mg

2) Doses will use the metric system and include dose/m2, dose/kilogram or AUC (area under the curve) where appropriate. The actual calculated dose will be included
3) Written as the amount per dose per day (e.g. cisplatin 20 mg/m^2 daily x 5 days, or cytarabine 3000 mg/m^2/dose every 12 hours on days 1,3, and 5)- NEVER written as total amount needed per course of therapy as this could be interpreted as daily dose

xi. Route and rate (if applicable) for administration
xii. Length of infusion (if applicable)
xiii. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)
xiv. Sequence of drug administration (if applicable)
~~xiv.~~**xv. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C**

c. Written using the generic name of the agent and free of any unapproved abbreviations used to identify the agent being prescribed. The pharmacist may clarify chemotherapy orders and write the generic name next to any commonly used abbreviation or brand names.
d. Free of any number prefixes such as "5-fluorouracil", which could be misinterpreted as part of the order dose or schedule requirements
e. Signed by a physician (MD or DO) in of Oncology or those who have been granted privileges to order chemotherapy before processed by the pharmacy
i. Signed by person drafting order if different then person signing order.
ii. Note: Pharmacy will not accept orders from Nurse Practitioners (NPs) and Physician Assistants (PAs) for any chemotherapy agent regardless of indication or use.
iii. Orders must be reviewed and re-signed every 6 months.
f. Accompanied by a copy and/or name of a readily available reference or the protocol name and number used in determining the prescribed regimen if the regimen is unfamiliar to the pharmacist.
i. The new protocol will be added to the pharmacy oncology literature file

~~2.~~**3.** Ex**cepp**~~ec~~tions

a. Physicians that are without chemotherapy privileges may write for chemotherapy only if they have been granted privileges by the medical staff to do so as related to their specialty including but not limited to:
i. Ectopic pregnancy
ii. Rheumatoid arthritis
iii. Systemic lupus erythematosus
iv. Certain dermatologic conditions
v. Certain ophthalmic procedures
vi. Other auto-immune conditions as identified in the literature.
~~vi.~~**vii. Androgen deprivation therapy for prostate cancer**
b. All ~~systemic~~ orders must be written on standard pre-printed "Chemotherapy Order Form" and subject to all other requirements stated above.
i. Use of standard pre-printed form is not required only if:
1) O~~o~~ral agent is prescribed for a non-malignant condition and may be ordered via CPOE.
~~1)~~**2) Androgen deprivation therapy is prescribed by a urologist or oncologist for prostate cancer.**
ii. Outpatient oral chemotherapy may be continued in-house by an attending physician via CPOE. Pharmacist shall verify that patient is currently on oral chemotherapy regimen.
c. Non-systemic chemotherapy such intrathecally, intravesically or directly in to an organ (i.e. chemoembolization) may be ordered and administered by a qualified physician in other

areas of the hospital (interventional radiology, operating room). Use of standard pre-printed "Chemotherapy Order Form" is not required

d. Oral chemotherapy for non-malignant condition (i.e. methotrexate for Rheumatoid arthritis) may be administered by non-chemotherapy credentialed RN who has been educated regarding safe handling and disposal of chemotherapy agent

C. **CHEMOTHERAPY PROCESSING POLICY:**

1. The pharmacist will confirm that the order has been prescribed according to the criteria above.
2. The pharmacist shall contact the physician to request that any order not meeting these criteria be changed.
3. All addendums or changes to original orders must be documented on a Chemotherapy Order Form. A copy will be placed with the chemotherapy work sheet and original order.
4. Changes to the order made by the physician (as above) must be double checked by a second pharmacist.
5. If there is a discrepancy in the medication order, nursing will be notified of the problem and the possible delay in the delivery of the medication.
6. Once the prescribing criteria have been met, the pharmacist is responsible for verifying the accuracy of the order by:
   a. Confirming the two patient identifiers
   b. Reviewing the diagnosis and prescribed regimen (drug name, dose, route and frequency)
   c. Calculating the patients' BSA, unit conversions and patient-specific dose
   d. Reviewing diluents, drug volumes, rate of administration, drug concentration requirements, drug stability, administration times, infusion guidelines and supportive care medications
   e. Verifying appropriate labs have been ordered and are within acceptable ranges for the ordered chemotherapy medications or if treatment modifications are indicated
   f. Reviewing the date the patient was last treated and then next planned treatment date to ensure the appropriate interval has elapsed since last treatment was administered
   g. Reviewing drug allergies and sensitivities along with adverse drug effect histories
   h. Current medication profile should be evaluated for potential drug interactions with antineoplastic therapy
7. Upon completion of the verification process, the pharmacist will prepare a chemotherapy work sheet for use in preparing the prescribed regimen. One worksheet must be filled out for each patient. The following information should be documented:
   a. Patient name second identifier (i.e DOB and/or medical record number)
   b. Height weight, body surface area, CrCl and any other pertinent labs
   c. Diagnosis, allergies, doctor's name, regimen name and protocol number (if applicable)
   d. Full generic medication name, dose/m2 or AUC, route, frequency and any special medication instructions that are different then institutional standards
   e. Appropriate cycle number and day along with corresponding date of treatment
   ~~e.~~**f. Cumulative dose for medications with dose ceilings**
8. The order shall be entered into the ~~pharmacy computer system~~ electronic medical record under the patient's medication profile.
9. A second pharmacist must verify the accuracy of the regimen, chemotherapy work sheet and corresponding entries in medication profile with each new cycle and initial the work sheet to signify approval.
   a. Changes in subsequent doses should be noted on the chemotherapy worksheet and must be double checked and initialed by a second pharmacist.
   b. Explanation of reason for changing subsequent doses shall also be documented.
10. If paper orders are used, a copy of the order shall be attached to the chemotherapy worksheet
11. On the day of treatment, the verifying pharmacist must check the following:
    a. The dose is within 5% of treatment plan dose based on the current weight.
       i. Any questions regarding weight that could affect the treatment regimen will be brought to the physician's attention.

b. Chemotherapy orders have not changed between the original regimen verification and the actual day of treatment.
c. Appropriate labs that are drawn within the appropriate time interval and are regimen specific.
   i. Labs will be evidence based when national guidelines (e. g ASCO/NCCN) exist or determined by practitioner.
   ii. Any abnormal lab values that could affect the treatment regimen will be brought to the physician's attention.
   iii. In the absence of treatment parameters, the lab values of ANC ≤ 1500 cells/µL, platelets ≤ 100,000/uL total bilirubin ≥ 1.4 mg/dL, CrCl <60 mg/dl (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved with physician before preparation of dose.
d. Ensure that the computerized order entry matches the order from which it was transcribed, or in the case of computerized physician order entry (CPOE), that the entry was inputted correctly.
   i. This includes drug name, dose, route, order of administration, diluent, volume, order comments and rate.
e. Confirm the cycle has been checked and signed off by two pharmacists.
f. The pharmacist that performs steps a-e above will initial the chemotherapy worksheet signifying that this part of verification has been done.
g. A second pharmacist will verify steps a-f above and initial chemotherapy worksheet.

12. The verification process must be followed completely before any dose can be prepared.

D. **CHEMOTHERAPY PREPARATION AND DISPENSING POLICY:**

1. The technician responsible for preparing the doses must gather the order, chemotherapy worksheet, patient-specific labels, medication, and associated supplies.
2. The technician is responsible for printing out a second "production" label for tracking purposes, indicating the following:
   a. Time and date the product was prepared
   b. Medication used, concentration and volume used
   c. The lot number/expiration date from the medication vial
3. The technician must initial the chemotherapy worksheet, product label and production label and perform all calculations associated with the compounding process.
4. If an oral chemotherapy drug is to be physically manipulated or repackaged into a larger gel cap the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.
5. All intravenous chemotherapy will be prepared using a Closed System Transfer Device (CTSD) whenever possible in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.
6. All parenteral chemotherapy medications need to be spiked and primed in the chemo hood if to be dispensed in IV piggyback.
7. The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be pulled back to indicated the measured volume or shown to the pharmacist before injecting into IV solution.
8. The pharmacist reviewing the prepared dose must check each prepared dose must check the patient specific label against the chemotherapy worksheet and original order. If CPOE is used, the pharmacist may check the label against the chemotherapy worksheet.
9. The pharmacist must ensure that the current cycle and verification boxes have been signed off on the chemotherapy work sheet.
10. The pharmacist, working independently must verify the final preparation includes:
    a. The correct medication has been used.
    b. The drug was reconstituted correctly using the correct volume and diluent
    c. The volume of drug used was accurately measured for the prescribed dose.
    d. The label is correct and includes at least:

i. Patient's full name and second patient identifier (i.e DOB or medical record number)
ii. Full generic drug name
iii. Drug administration route
iv. Total dose to be given
v. Total volume required to administer dosage
vi. Date of administration
vii. Date and time of preparation
viii. Date and time of expiration if not for immediate use
ix. Special handling instructions and caution statements (i.e intrathecal use only)
x. Final concentration of product on syringe labels (i.e doxorubicin 50mg/ 25ml)
xi. All minibag or large volume parenterals include volume of each component as well as a total volume and rate of administration.

e. Final container integrity and correct type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.
f. All intrathecal doses
   i. Must not be prepared during preparation of any other agents
   ii. Be uniquely labeled with an identifiable intrathecal medication label
   iii. Must be placed in a separate transport bag
   iv. Be delivered to the patient only with other medications intended for administration intrathecally
g. Any IVP dose in syringe should be less than three quarters full to minimize the risk of chemo spill.
h. Maximum syringe size dispensed should be 30 mL
i. An overfill volume of 0.05 ml will be added to all subcutaneous doses

11. Upon completing the chemotherapy preparation process, the final product shall be affixed with patient specific labels
12. All oral chemotherapeutic agents regardless of indication shall be dispensed from the pharmacy with an auxiliary Chemotherapy Warning label
13. The pharmacist must sign their initials on the chemotherapy work sheet, patient specific label and tracking label to signify product verification.
    a. The pharmacist must ensure the technician has initialed all aforementioned places as well.
14. The chemotherapy doses are placed in a sealable chemotherapy transport bag.
15. If the chemotherapy is to leave the building, it must be double bagged and placed in a transport cooler with a spill kit inside.

E. REFERENCES

1. Neuss, M. N; et al. (2013) Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards Including Standards for the Safe Administration and Management of Oral Chemotherapy. *Journal of Oncology Practice.*
2. American Society of Health-System Pharmacists. ASHP guidelines on preventing medication errors with antineoplastic agents. Am J Health-Syst Pharm. 2002; 59:1648–68.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~POLICY~~ MANUAL

ISSUE DATE: 05/92	**SUBJECT: Clinical Intervention/Activity Documentation Program**
REVISION DATE: 05/97, 01/97, 08/00, 02/03, 07/06 1/12, ~~3/15~~	**~~POLICY NUMBER: 8390-6015~~**
Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval Date(s):	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

A. **PURPOSE**:

1. To **provide a process for documentation of daily clinical pharmacy activities and programs, implemented for patient safety and cost-saving initiatives.**

~~1.~~**2.** **To provide a process for tracking and reporting of clinical intervention documentation activities for financial and quality improvement purposes and medication error reduction.** ~~document clinical pharmacy activities daily using the attached documentation sheet. This allows Pharmacy to assess clinical pharmacy workload, identify "high risk" prescriptions, track and trend common pharmacist interventions, and evaluate the impact of clinical pharmacist activities (financial and medication error prevention) here at TCMC.~~

B. **PROCEDURE**:

1. During each pharmacy shift, the clinical pharmacist will **document ~~all~~ clinical pharmacy activities in** ~~use the~~ Cerner **or other designated documentation /tracking** system to record all patient related clinical activities.

2. The pharmacist will select the appropriate section and document the details of any cost savings interventions or therapeutic interventions that have a significant impact on patient care. **Common interventions include but are not limited to:**

- **a. Antibiotic Stewardship**
- **b. Renal Dose Adjustment**
- **c. Therapeutic Substitution**
- **d. IV to PO Conversion**
- **e. Therapeutic Duplication**
- **f. Drug-Disease Interaction**
- **g. Drug-Drug Interaction**
- **h. Physician Near Miss**
- **i. Dose, Duration, Frequency Optimization**
- **j. Adverse Drug Event**
- **k. Anticoagulation, Vancomycin, Aminoglycoside, TPN Consults**
- ~~a.~~**l. Drug Information Question**

~~1. The pharmacist will document the number of occurrences that were completed during the shift for that day. (ie: if the pharmacist did 3 new kinetic consults he/she would record 3 on item #2 of the Daily Pharmacist Consultation Log). The pharmacist will leave the completed Daily Pharmacist Consultation Log in the mailbox of the Clinical Pharmacist Specialist for tracking and trending.~~

3. Data will be ~~tabulated, complied~~ **collected and summarized** monthly **by the IT Pharmacy Analyst or Designee.**

~~2. , and reported quarterly at the Pharmacy and Therapeutics Committee meeting. Allergic reactions prevented, Major dosing errors, Other major interventions, and cost saving interventions will all be tracked and reported. "High Risk" prescriptions and medication error prevention will also be reported to the physicians via the Pharmacy and Therapeutics Committee quarterly Newsletter.~~

~~2.~~4. **Pharmacy Clinical Interventions shall be reviewed monthly by the Clinical Manager and reported to the Pharmacy and Therapeutics Committee meeting, as appropriate.**

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PHARMCY ~~POLICY~~ MANUAL

DELETE - Combined in Therapeutic Drug Monitoring, Vancomcyin, Aminoglycoside and Anticoagulation Procedures

~~**ISSUE DATE: 10/92**~~ ~~**SUBJECT: Clinical Protocol Drug Therapy Consults**~~[AMH1]

~~**REVISION DATE: 10/94, 05/97, 08/00, 02/03, 07/06, 1/12**~~ ~~**POLICY NUMBER: 8390-6009**~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

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

~~Any official written order (i.e., physician order sheet) for a "Pharmacy Consult" or similar wording will be acted on at the earliest possible convenience by the clinical pharmacist who initially receives the order. If a technician first receives the order, he/she will notify a clinical pharmacist immediately.~~

~~B. **PROCEDURE**:~~

~~1. If the consult is for an established clinical service, the procedure for that service will be initiated.~~
~~2. If the reason for the consult is unclear or not for an established clinical service, the clinical pharmacist will verbally contact the ordering physician for clarification.~~
~~3. If, after discussion with the ordering physician, it is determined that a pharmacy consult is not required, the clinical pharmacist will write a verbal order to cancel the consult:~~
~~4. "Cancel Pharmacy Consult At This Time"~~
~~5. If, after discussion with the ordering physician, it is determined that a pharmacy consult is required, the clinical pharmacist will write at least one formal "Clinical Pharmacy Note" in the progress note section of the patient's chart advising the physician of his/her recommendations.~~
~~6. The Clinical Pharmacy Coordinator will be notified as soon as possible regarding all (canceled or not) orders for "Pharmacy Consult" which are not for established clinical services.~~

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PHARMACY ~~POLICY~~ MANUAL

DELETE - Unnecessary or duplicate content covered in Therapeutic Drug Monitoring, Order Verification, Anticoagulation , Vanco and Aminoglycoside Procedures

~~**ISSUE DATE: 07/95**~~ ~~**SUBJECT: Completion of Therapeutic Drug Monitoring Profiles**~~ [AMH1]

~~**REVISION DATE: 09/96, 08/00, 02/03, 07/06, 1/12**~~ ~~**POLICY NUMBER: 8390-6013**~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

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

1. ~~The following policies will be implemented:~~
   a. ~~The pharmacist will be required to check all patients on coumadin as per existing procedures. This includes review with charge RN using census and laboratory cumulative protime list.~~
   b. ~~When transferring patients from in-house to Rehab from Orthopedics, and patient's coumadin is continued, the pharmacist responsible for will continue to follow patient for the rest of their shift and give completed profile to Rehab pharmacist.~~
   c. ~~The pharmacist will be required to fill in dosing history as follows:~~
      i. ~~Initial loading dose and time started~~
      ii. ~~Record the dose (if present) that was given previous to levels (see example)~~
      iii. ~~After dosage adjustment, record new starting time (see example)~~
      iv. ~~Record regimen on front (Page 1) of monitoring sheet daily. (It is not necessary to record every dose.)~~
   d. ~~The pharmacist will be required to fill out the following items on the profile. These policies only pertain to what the standard will be for recording information on the drug monitoring form. They do not represent a new standard differing from current protocol. The pharmacist is still responsible for monitoring other physiologic parameters that will predict drug clearance (i.e., urine output).~~

B. ~~**ANTICOAGULATION PROFILE**~~:

1. ~~Room Number~~
2. ~~Patient Name~~
3. ~~Sex~~
4. ~~Age~~
5. ~~Date~~
6. ~~Medical Record~~
7. ~~Hospital ID~~
8. ~~Height~~
9. ~~Weight~~
10. ~~Consulting Physician~~
11. ~~Blood Volume~~
12. ~~Indication for Anticoagulation~~
13. ~~Therapeutic Goal~~
14. ~~Circle Consulted Drug~~
15. ~~Re-bolus~~
16. ~~Daily Notation with Initials~~
17. ~~Initial All Labs Recorded~~

C. ~~**PHARMACOKINETICS PROFILE**~~:

1. ~~Room Number~~
2. ~~Patient Name~~
3. ~~Sex~~

4. ~~Age~~
5. ~~Medical Record~~
6. ~~Hospital ID~~
7. ~~Consult (Y/N)~~
8. ~~Height~~
9. ~~Weight~~
10. ~~Consulting Physician~~
11. ~~Indication for Consulted Drug~~
12. ~~Drug~~
13. ~~Date~~
14. ~~Dose~~
15. ~~Population Parameters~~
16. ~~Estimated Goal for Peak/Trough~~
17. ~~Record All Measured Peak/Trough Values~~
18. ~~BUN~~
19. ~~Serum Creatinine~~
20. ~~Culture and Sensitivity with Date and Results~~
21. ~~Dosing History as in #4 of this policy. It is not necessary to record every dose.~~

Tri-City Medical Center
Oceanside, California

DELETE - Covered in Controlled Substances - Pharmacy

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 06/05~~ ~~SUBJECT: Controlled Substances~~

~~REVISION DATE: 07/06[v1],~~ ~~POLICY NUMBER: 8390-4304~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

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

~~The purchase, storage, distribution and accounting of controlled substances (CS) will be done in accordance with all federal and state laws and standards of professional practice to maintain optimal quality control over these high-risk medications and to prevent diversion. The Pharmacy Department is responsible for compliance with this policy.~~

~~B. **PROCEDURE**:~~

~~1. Registration: The hospital will hold current registration with the Drug Enforcement Administration (DEA) and appropriate state licensure.~~

~~2. Purchase/Receipt: All invoices for controlled substances in schedules II, III, IV and V will be maintained in a readily retrievable file according to federal guidelines. Invoices for controlled substances will be marked with a red "C" for filing. The purchaser copy of DEA-222 forms will be kept in a separate file for all C-II purchases.~~

~~3. Records/Distribution: A transaction record for all controlled substances in schedules II, III and IV (C-II, C-III, C-IV) will be maintained by the hospital. All controlled substance records will be maintained for the period required by law and be readily retrievable.~~

~~a. A perpetual inventory record of all C-II–V substances stored in the main Pharmacy will be maintained.~~

~~b. When controlled substances in schedules II, III, IV and V are transferred outside of the main Pharmacy, a record is created in the Pyxis CII safe for auditing and tracking of controlled medications.~~

~~4. Discrepancy: All discrepancies are resolved and reviewed by CS technician.~~

~~5. Physician DEA Registration: Only physicians with registration numbers may prescribe controlled drugs.~~

~~6. Security: All controlled substances in schedules II–V will be stored in locked security. Only licensed personnel or authorized personnel under the direct supervision of licensed personnel shall have access to controlled drugs stored within the hospital. Licensed personnel include: nurses, pharmacists, physicians and pharmacy technicians.~~

~~7. Destruction: Destruction of all controlled substances within the RX must be done in the presence of two (2) licensed individuals, one of which must be a pharmacist. Destruction of patient's own controlled substances left behind after discharge must be wasted in the presence of two (2) pharmacists.~~

~~8. Theft: All unauthorized losses shall be reported to the appropriate state and federal authorities. Theft or significant loss is to be reported on DEA form 106.~~

~~Biannual Inventory: Every two (2) years a complete inventory count of all controlled drugs will be conducted and kept on file in the pharmacy department pursuant to state and federal laws.~~

Tri-City Medical Center
Oceanside, California

PHARMACY ~~POLICY~~ MANUAL

ISSUE DATE: 09/90	**SUBJECT: Controlled Substances - Pharmacy**
REVISION DATE: 01/97, 12/97, 06/05, 07/06~~, 5/15~~	**~~POLICY NUMBER: 8390-2106~~**
Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**02/03, 06/05, 07/06, 07/09, 1/12**

A. **POLICY**:
1. The Pharmacist in Charge (PIC) is responsible for the proper safeguarding of controlled substances within the Hospital.
2. The PIC is responsible for the purchase, storage, accountability and proper dispensing of controlled substances.
3. All applicable state and federal laws governing the handling of controlled substances will be enforced.
4. The Pharmacy Department utilizes a perpetual inventory system for all Schedule II-V controlled substances. The PIC is responsible for assuring the accuracy and completion of the perpetual inventory system.

B. **PROCEDURE:**
1. Registration:
   a. The hospital will hold current registration with the Drug Enforcement Administration (DEA) and appropriate state licensure.
   b. The individuals authorized to sign the DEA Form 222 and Controlled Substance Ordering System (CSOS) will include the ~~Pharmacy Operations Manager~~**Director of Pharmacy**, Pharmacy ~~Purchasing Agent~~**Buyer**, and anyone else deemed appropriate and necessary.
   ~~b.~~**c. Only physicians with valid registration numbers may prescribe controlled substances.**
2. Pharmacy Receipt of Controlled Substances:
   a. The receipt of all Schedule II-V controlled substances is documented in the perpetual inventory system in the CII safe.
   b. Upon receipt of controlled drugs, ~~the packaging is opened and~~ the count, condition and identification of the drugs are verified by a pharmacist.
   c. The Pharmacy Buyer shall fill out the retained copy of the DEA Form 222 for all Schedule II drugs, indicating the amount received and date.
   ~~c.~~**d. For Schedule II, a copy of the wholesaler's invoice, CII Safe Receive Log Sheet, and copy of DEA 222 will be filed separately in a readily retrievable manner and will be maintained for the period required by law.**
   ~~a.~~**e.** For Schedule III-V, a copy of the wholesaler's invoice and CII Safe Receive Log Sheet will be filed in a readily retrievable manner and will be maintained for the period required by law.
   ~~b. For Schedule II, a copy of the wholesaler's invoice, CII Safe Receive Log Sheet, and copy of DEA 222 will be filed separately in a readily retrievable manner and will be maintained for the period required by law.~~
   ~~3.~~**f.** Discrepancies in shipment that cannot be resolved immediately with the wholesaler shall be reported to the PIC.
~~a.~~**3.** Pharmacy Storage **and Security**:

~~b.~~**a.** All Schedule II-V drugs are stored in the Pyxis cabinet (C-II Safe) or locked cabinet in the refrigerator.

~~4.~~**b. Only licensed personnel shall have access to controlled drugs with the hospital.**

~~a.~~**4.** Dispensing ~~to Patient Care Units:~~ **and Distribution:**

~~b.~~**a.** All Schedule II, III, IV and V drugs are dispensed to the patient care units **and stored in an automated dispensing machine. Exceptions: See Pharmacy Policy Floor Stock.** ~~as secured floor stock.~~

~~c.~~**b. Par levels**~~The restocking amounts of~~ **for** controlled ~~drugs~~ **substances** ~~is~~ **are** automated utilizing the C-II Safe and the Pyxis Medication Stations. The Pharmacy Department will **re-stock and** fill ~~the~~ orders on a daily basis.

~~d.~~**c.** The **Pharmacy** Technician fills the order and the order is checked by ~~a~~ **a second technician or a** pharmacist prior to delivery to the nursing unit. ~~On delivery to the floor the amount is then added to the unit's stock, a new balance is calculated and audit trail established with the automated C-II Safe.~~ **Upon refill, a perpetual inventory is updated with the refill amount. Activity** ~~R~~reports are generated and reviewed for audit purposes.

~~e.~~**d. Controlled substance discrepancies will be resolved according to Patient Care Services Policy Controlled Substances Management Policy and Pharmacy Policy** ~~**Pyxis Medstation System.**~~**Automated Dispensing Machine.**

~~2.~~**5.** Inventory System:

~~e.~~**a.** In the CII Safe a physical inventory is done monthly and is compared to the computed balance in the perpetual inventory system. Any discrepancy that cannot be resolved will be reported to the PIC immediately.

~~a.~~**b.** Every two (2) years a complete inventory count of all controlled drugs will be conducted and kept on file in the pharmacy department pursuant to state and federal laws.

~~5.~~**6. Destruction:**

~~b.~~**a. Destruction of all controlled substances with the pharmacy must be done in the presence of two (2) licensed individuals, one of which must be a pharmacist.**

~~c.~~**b. Destruction of patient's own controlled substances left behind after discharge must be wasted in the presence of two (2) pharmacists.**

~~3.~~**7.** Suspected Tampering/Loss:

a. If tampering with **or loss of** a controlled substance is suspected the PIC ~~should~~ **shall** be notified immediately and an investigation shall be initiated. (See Employee Theft or Impairment Policy)

b. All unauthorized losses shall be reported to the appropriate state and federal authorities.

Tri-City Medical Center
Oceanside, California

DELETE - Drug Information, content not necessary to be included in policy

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 04/97~~ [AMH1] ~~SUBJECT: Digifab Use in Digoxin Toxicity~~

~~REVISION DATE: 05/02, 09/00, 07/06~~ ~~POLICY NUMBER: 8390-10013~~

Department Approval Date(s):	04/15
Pharmacy & Therapeutics Committee Approval:	07/06, 07/09, 1/12, 05/15
Medical Executive Committee Approval:	07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval Date(s):	07/15
Board of Directors Approval:	07/06, 07/09, 1/12

~~A. **PURPOSE**:~~
~~To provide information regarding the use of DigiFab in the treatment of acute digoxin toxicity.~~

~~B. **INDICATIONS**:~~
~~The treatment of potentially life threatening digoxin intoxication.~~

~~C. **CONTRAINDICATIONS**:~~
~~Known hypersensitivity to DigiFab.~~

~~D. **DOSING GUIDELINES**:~~
~~1. Serum level and digoxin ingestion is unknown:~~
~~a. Adults 20 vials~~
~~b. Children 10 vials initially, repeat with additional 10 vials prn~~
~~2. Known serum digoxin concentration (adults):~~

~~Adult Dose Estimate of DigiFab (in # of vials) from Steady-State Serum Digoxin Concentration~~

~~Patient Weight (kg)~~	~~Serum Digoxin Concentration (mg/ml)~~						
	~~1~~	~~2~~	~~4~~	~~8~~	~~12~~	~~16~~	~~20~~
~~40~~	~~0.5v~~	~~1v~~	~~2v~~	~~3v~~	~~5v~~	~~7v~~	~~8v~~
~~60~~	~~0.5v~~	~~1v~~	~~3v~~	~~5v~~	~~7v~~	~~10v~~	~~12v~~
~~70~~	~~1v~~	~~2v~~	~~3v~~	~~6v~~	~~9v~~	~~11v~~	~~14v~~
~~80~~	~~1v~~	~~2v~~	~~3v~~	~~6v~~	~~10v~~	~~13v~~	~~16v~~
~~100~~	~~1v~~	~~2v~~	~~4v~~	~~8v~~	~~12v~~	~~16v~~	~~20v~~

~~[v = vials]~~

~~3. Known serum digoxin concentration (infants and small children):~~

~~Infants & Small Children Dose Estimates of DigiFab (in mg) from Steady-State Serum Digoxin Concentration~~

~~Patient Weight (kg)~~	~~Serum Digoxin Concentration (mg/ml)~~						
	~~1~~	~~2~~	~~4~~	~~8~~	~~12~~	~~16~~	~~20~~
~~1~~	~~0.4*mg~~	~~1*mg~~	~~1.5*mg~~	~~3*mg~~	~~5mg~~	~~6mg~~	~~8mg~~
~~3~~	~~1*mg~~	~~2*mg~~	~~5mg~~	~~9mg~~	~~14mg~~	~~18mg~~	~~23mg~~
~~5~~	~~2*mg~~	~~4mg~~	~~8mg~~	~~15mg~~	~~23mg~~	~~30mg~~	~~38mg~~
~~10~~	~~4mg~~	~~8mg~~	~~15mg~~	~~30mg~~	~~46mg~~	~~61mg~~	~~76mg~~
~~20~~	~~8mg~~	~~15mg~~	~~30mg~~	~~61mg~~	~~91mg~~	~~122mg~~	~~152mg~~

~~*Dilution of reconcentrated vial to 1mg/ml may be desirable~~

4. Known number of digoxin tablets ingested:

Approximate DigiFab Dose for Reversal of a Single Large Digoxin Overdose	
Number of Digoxin Tablets or Capsules Ingested*	DigiFab Dose
	# of vials
25	10
50	20
75	30
100	40
150	60
200	80

*0.25mg tablets with 80% bioavailability or 0.2mg Lanoxicaps Capsules with 100% bioavailability

E. **PRECAUTION:**

1. Serum digoxin levels can be clinically misleading after DigiFab use.
2. Serum potassium should be monitored closely after DigiFab use.

F. **PREPARATION:**

Reconstitute each vial with 4mls sterile water. Dose can be further diluted with NS for ease of administration. Total dose should be given IV over 30 minutes through a 0.22 micron filter. Each vial contains 33mg of DigiFab.

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 05/94	**SUBJECT: Floor Stock**
REVISION DATE: 02/97, 08/00, 06/05, 07/06, 5/15	**~~POLICY NUMBER: 8390-2105~~**
Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**02/03, 06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**02/03, 06/05, 07/06, 07/09, 1/12**

A. **POLICY:**

1. Responsibility for control of floor stock medications within this hospital rests with the Pharmacy Department. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital. ~~These policies will be approved by the Pharmacy and Therapeutics Committee.~~

B. **PROCEDURE**:

1. Floor Stock: Medications **that** are maintained **outside of a Automated Dispensing Machine (ADM)** in specific areas of the hospital,~~. such as Endoscopy and Cardiac Catheterization Labs and Surgery~~. These medications are intended for use by licensed independent practitioners with appropriate clinical privileges who are responsible for ordering, preparing and administering drugs.
   a. Medications contained in floor stock are stored in a secured, locked cabinet. Responsibility for security of the floor stock rests with the supervising licensed practitioner or nurse overseeing the unit in which the floor stock is stored.
   b. Medications contained in floor stock are stored under the conditions listed by the medication manufacturer to ensure stability.
   c. **Medications designated as** ~~F~~floor stock ~~drugs~~ are requisitioned from the Pharmacy Department by the nurse or practitioner in quantities sufficient for anticipated needs.
   d. As with all other medications, all floor stock ~~(medications and chemicals)~~ used to prepare medications **(i.e diluent bags, diluent vials, etc)** are accurately labeled with contents, expiration dates and appropriate warnings.
   e. Controlled ~~drugs~~ **substances designated as** ~~for~~ floor stock are requisitioned according to ~~the~~**Pharmacy P**~~policy on controlled drugs~~**Controlled Substances**~~.~~ **~~and~~, stored in a securely locked, substantially constructed cabinet and inventoried weekly by two licensed personnel.**
2. Inspection: All floor stock supplies within the hospital will be inspected monthly by the Pharmacy Department. A report of inspection will be maintained by the Pharmacy Department. Reports **noting any** ~~of~~ discrepancies will be ~~shared~~**reviewed by the pharmacist in charge and shared with** ~~with~~ the supervising ~~professional~~ **personnel** of the unit involved.

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 04/73	**SUBJECT:** Licensure and Professional Standards
REVISION DATE: 07/06, 1/12, ~~3/15~~	~~**POLICY NUMBER: 8390-8008**~~
Department Approval:	05/15
Pharmacy & Therapeutics Committee Approval:	06/05, 07/06, 07/09, 1/12, 05/15
Medical Executive Committee Approval:	06/05, 07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	06/05, 07/06, 07/09, 1/12

A. **POLICY**:

1. The Pharmacy Department will operate within all applicable state and federal laws, regulations and licensure requirements. In matters of professional judgment or practice standards, **recommendations from** the American Society of Health-System Pharmacists (ASHP) and **T**~~t~~he Joint Commission ~~on Accreditation of Healthcare Organizations (JCAHO) recommendations~~ will be given first consideration and priority.
2. State of California: (Example)
   a. Pharmacy Department~~s~~ **services** will be provided according to the regulations of the Department of Health Services as stated in Title 22 for licensed acute care hospitals. These requirements will be integrated into policies and procedures where necessary.
      i. Pharmaceutical Services Definition (section 70261)
      ii. Pharmaceutical Services General Requirements (section 70263)
      iii. Pharmaceutical Services Staff (section 70265)
      iv. Pharmaceutical Services Equipment and Supplies (section 70267)
      v. Pharmaceutical Services Space (section 70269)
   b. All laws, regulations and licensure requirements of the California State Board of Pharmacy will be met and followed.
      i. The hospital's Pharmacy Department will have at all times a valid and current pharmacy permit issued by the board which will be posted in public view.
      ii. All Pharmacists, ~~Pharmacist~~ **Pharmacisty** Interns and Pharmacy Technicians must maintain valid and current licensure with the board according to law and hospital policy. A photocopy of **license verification** ~~the current renewal receipt~~ will be kept in the **HR** personnel file.
      ~~ii.~~**iii.** **All Pharmacists, ~~Pharmacy~~ Intern Pharmacists~~s~~, and Pharmacy Technicians shall renew licensure per Administrative Policy Monitoring Licenses, Professional Registrations, and Certificates 430.~~within 10 days of expiration. License verification is displayed on the board's website and includes the issuance and expiration dates of any license issued by the board.~~**
      ~~iii. Pharmacy Technicians may be registered with the board, however this is not required. Copies of the current registration will be kept in the personnel file.~~
      iv. A current copy of State Pharmacy Law with Rules and Regulations ~~will be~~**is** available **on the California Board of Pharmacy website.** ~~in the Pharmacy Department at all times.~~
3. Federal:
   a. The hospital will comply with all laws, regulations and requirements of the Drug Enforcement Administration (DEA).
      i. The hospital will maintain current and valid registration with DEA. The registration certificate will be posted in public -view in the Pharmacy.

ii. All required records will be maintained by the Pharmacy Department, including order forms (DEA-222), disposal (DEA-41), loss (DEA-106) and the biannual inventory.

iii. In accordance with DEA regulations, all schedules II, III, IV and V (CII, CIII, CIV & V) drugs will be stored separately in a locked cabinet in the main Pharmacy, automated drug dispensing machines on the patient care units or double-lock storage cabinets in ancillary areas. Access is restricted to licensed personnel.~~ or Pharmacy Technicians under the supervision of a Pharmacist.~~ **~~See also Pharmacy Policy Hours of Operation and Authorized Access to the Pharmacy~~.**

b. The Pharmacy Department will comply with the Conditions of Participation for Medicare of the Centers of Medicare and Medicaid Services.

4. Practice Standards:

a. Dispensing: A Pharmacist will review each medication ~~order~~ prior to dispensing. **Exceptions to this can be found in the Pharmacy Technician Checking Technician Program Policy**

b. Staffing Guidelines: The ratio of Pharmacy Technicians to Pharmacists will not exceed 2:1**, except that this ratio shall not apply to personnel performing clerical functions pursuant to California Code of Regulations~~Section 4116 or 4117~~** and the ratio of ~~Pharmacist~~ **Pharmacy** Interns **Pharmacists** to Pharmacists will not exceed **2**~~1~~:1 at any time.

B. RELATED DOCUMENTS

~~b.~~**1. Administrative Policy Monitoring Licenses, Professional Registrations, and Certificates 430**

Tri-City Medical Center
Oceanside, California

DELETE - Covered in Pharmacist order verification & Drug Distribution Policy

PHARMACY ~~POLICY~~ MANUAL

~~ISSUE DATE: 05/94~~ ~~SUBJECT: Medication Orders (Pharmacy)~~

~~REVISION DATE: 01/97, 08/00, 07/06~~ ~~POLICY NUMBER: 8390-3102~~ [v1]

Department Approval:	05/15
Pharmacy & Therapeutics Committee Approval:	02/03, 06/05, 07/06, 07/09, 1/12, 05/15
Medical Executive Committee Approval:	02/03, 06/05, 07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	02/03, 06/05, 07/06, 07/09, 1/12

~~A. **POLICY**:~~
~~Medication orders shall be processed and dispensed only after being reviewed and checked by a Pharmacist with the noted exception: medications may be given without a pharmacist review in an urgent or emergent situation to prevent harm occurring to patient.~~

~~B. **PROCEDURE**:~~
~~1. All direct copies of physician orders shall be transcribed by means of entering in the computer by the Pharmacist.~~
~~a. Pharmacist shall check for:~~
~~i. Completeness of the drug order~~
~~ii. Correctness of the drug order~~
~~iii. Drug allergies~~
~~iv. Drug incompatibilities~~
~~v. Appropriate dosage, route, frequency and indications~~
~~2. Any questions or clarifications regarding the physician drug order shall be directed to the physician by the Pharmacist or directed by the Pharmacist to the nurse to obtain the clarification.~~
~~a. Physicians shall be contacted by verbal or written communications.~~
~~b. Telephone orders shall be written in the patient's chart if any drug orders are changed.~~
~~c. Face to face verbal orders are accepted only in emergency situations.~~
~~3. Drugs shall be dispensed only after review of the physician order by the Pharmacist.~~
~~a. In the event of a conflict between the prescriber and the Pharmacist, the issue shall be escalated to the Clinical Specialist. If needed, the Chief of Staff can be consulted for arbitration after consultation with the Pharmacy and Therapeutics Committee chairman.~~

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 06/80	**SUBJECT: Medication Preparation**
REVISION DATE: 07/06, 5/15	**~~POLICY NUMBER: 8390-4102~~**
Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

B. **POLICY**:

1. **Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form will be used.**
2. **For medications not commercially available in unit dose form, medications will be repackaged from bulk containers into single unit packages so that they may be used in a unit dose system whenever possible.**

~~1.~~**3.** All medications are prepared in a safe manner.

C. **PROCEDURE**:

1. To prevent contamination of medications prepared by the Pharmacy Department, and to prevent medication errors, the following guidelines will be followed in the preparation of medications:

~~a. Ensure legibility of the prescription. The Pharmacist must be able to positively identify the drug name, dose and quantity before processing the prescription. The prescriber will be contacted for all ambiguous or questionable prescriptions.~~[AMH1]

~~b. No medication will be brought into the institution by a health care provider outside the normal pharmacy acquisition process except as stated in PCS Policy IV.I.6 B3.~~[AMH2]

~~c. In preparing medications, Pharmacy staff will use appropriate techniques to assure accuracy in the preparation.~~

~~i. The patient's profile will be screened to detect dosage problems, potential contraindications, drug-drug interactions, drug-disease interactions, drug-laboratory interactions and therapeutic duplication.~~

~~ii. Patient profiles will be formatted to contain prescription, over-the-counter and alternative (herbal) medications.~~

~~iii. Relevant patient-specific information (such as allergy history, labs, medical history, etc.) and therapy goals will be readily available to the Pharmacist.~~

~~iv. The most current drug reference information will be maintained in the Pharmacy Department. Outdated references will be removed from use.~~

~~v. A review of all clinically significant warnings generated by the Pharmacy computer system during order entry will be conducted.~~

~~vi. Pharmacy Technicians will only perform routine functions within the scope of their training and education.~~[AMH3]

a. **The medication preparation and packaging operation will be isolated, to the extent possible, from other pharmacy activities.**
b. **The preparation area will be maintained in a clean and uncluttered manner, functionally separate area for product preparation to minimize the possible of contamination.**
c. Pharmacists and technicians will prepare only one (1) drug product at a time. **No drug products other than the one being repackaged or prepared will be present in the**

immediate preparation area. No other labels other than for the product being repackaged should be present in the area.

d. Pharmacists and technicians ~~will~~shall use clean or sterile techniques as appropriate to the medication being prepared. For injectable products, see Pharmacy Policy Sterile Product Preparation.

~~a.~~e. All unused labels (if separate labels are used) should be removed from the immediate preparation area.

~~b.~~f. The integrity of the product being prepared and medications ready to dispense will be examined for evidence of damage, contamination, or other deleterious effects

g. The Pharmacist will be readily accessible to Pharmacy T**echnician** staff during medication preparation.

~~d.~~h. Unit dose packages and labels will comply with law and regulation standards. See Pharmacy Policy Labeling Standards.

~~e. In preparing medications, Pharmacy staff will use appropriate techniques to avoid contamination during medication preparation, which includes, but is not limited to the following:~~

~~i. Use of clean or sterile technique as appropriate to the medication being prepared.~~

~~ii. Maintaining clean, uncluttered and functionally separate areas for product preparation to minimize the possible of contamination.~~

~~iii. Use of a laminar airflow hood or other class 100 environment while preparing any intravenous (IV) admixture in the Pharmacy, any sterile product made from nonsterile ingredients, or any sterile product that will not be used within 24 hours, including the compounding of parenteral and eye and ear preparations. These processes will only be performed by personnel who have received training in proper aseptic technique.~~

~~iv. Only the Pharmacy Department will compound or admix sterile medications, intravenous admixtures or other drugs except in emergencies or when not feasible.~~[AMH4]

~~v. The Pharmacy Department will compound or prepare patient-specific medications when they are necessary.~~

~~vi. Standard formulations or recipes for all compounded pharmaceuticals, along with appropriate references for those recipes will be maintained.~~

~~1) Medications should not be compounded if a suitable and similar commercially available product exists.~~[AMH5]

~~vii.~~**i.** Expiration dates will be checked **and verified** on all **products** ~~orders and expired dates on all Pharmacy compounded products.~~**prior to dispenseing.**

~~viii. The integrity of prepared medications and medications ready to dispense will be assessed through visual observation.~~

~~ix. Verbal orders for chemotherapy will not be accepted. There must be a written order for chemotherapy, with a minimum standard of documentation of clear facsimile (fax) acceptable.~~[AMH6]

~~x. A Pharmacist will verify technician work prior to dispensing. No medications will be dispensed without verification by a Pharmacist.~~

~~xi. Unit dose (unit-of-use) medications will be utilized to the greatest extent possible.~~

~~xii.~~**j.** High-risk medications will be stocked and stored in a way that minimizes the likelihood of an ~~dispensing~~ error **occurring during preparation and distribution**.

~~xiii. All verbal (telephone) orders received in the Pharmacy will be read back to the prescriber to assure accuracy. Information will be requested to confirm the patient's identification.~~

k. All ~~drugs~~medications will be packaged and stored in a temperature-and humidity-controlled environment to minimize degradation caused by heat and moisture. Arelative humidity of 75% at 23 °C should not be exceeded. Packaging materials should be stored in accordance with the manufacturer's instructions and any applicable regulations.

l. Applicable FDA and USP requirements concerning the type of package required for specific drug products will be followed.

~~B. **PHARMACY COMPUTER SYSTEM:**~~

~~1.~~**m.** To optimize medication preparation and dispensing and to reduce the likelihood of medication preparation and dispensing errors, the Pharmacy Department utilizes a computerized **order entry system and automated storage and distribution** system~~m. The Pharmacy computer system is used to compare all new medication orders/prescriptions against the patient's profile to detect dosage problems, potential contraindications, drug-drug interactions, drug-disease interactions, drug-laboratory interactions and therapeutic duplication before dispensing.~~ [AMH7]

n. The Pharmacy computer system includes **special alerts/staff reminders identifying problematic drugs such as high-alert medications, look-alike and sound-alike drug names or medications with complicated/problematic packaging or labeling.**~~the following features :~~

~~i. The ability to set sensitivity of drug-drug interaction warning flags to reduce the presence of non-clinically relevant warnings.~~

~~ii. Automation of dose range checks and a warning flag informing practitioners about potential over/under dosages.~~

~~iii. Allergy checks.~~

~~iv. Special alerts/staff reminders identifying problematic drugs such as high-alert medications, look-alike and sound-alike drug names or medications with complicated/problematic packaging or labeling.~~

~~C. **PERFORMANCE IMPROVEMENT:**~~

~~1. A performance improvement program to facilitate the identification of systems that prevent the recurrence of medication preparation, processing and dispensing errors and near misses is implemented within the Pharmacy Department. The Pharmacy performance improvement designee assesses the system for real and potential risk factors that could lead to errors and identifies potential system changes that may minimize the potential for error.~~

~~a. Preparation and dispensing errors are identified and reported to the Pharmacy Supervisor.~~

~~b.~~**a.** ~~The program is conducted on an ongoing basis with data submitted for review and analysis on a monthly basis to the Pharmacy Supervisor.~~ [AMH8]

Tri-City Medical Center
Oceanside, California

DELETE - Covered in Therapeutic Drug Monitoring, Anticoagulation, Vancomycin and Aminoglycoside Procedures

PHARMACY ~~POLICY~~ MANUAL

~~**ISSUE DATE: 05/92**~~ ~~**SUBJECT: Pharmacist's Therapeutic Intervention**~~ [AMH1]

~~**REVISION DATE: 05/94, 01/97, 08/00, 02/03 07/06**~~ ~~**POLICY NUMBER: 8390-6002**~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

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

~~1. When a medication is prescribed by a physician, every patient will have their drug profiles reviewed by a Pharmacist for potential drug interactions, therapeutic duplication and appropriateness of dosage.~~

~~2. At the time a medication is entered into the medication profile system, the Pharmacist will review the order for potential drug interactions, therapeutic duplication, subtherapeutic or supratherapeutic dosage. The Pharmacist must validate the entry of any medications by initialing the order.~~

~~3. Patients receiving specific therapies (i.e., selected antibiotics, anticoagulation, parenteral nutrition, drugs exhibiting narrow therapeutic index) will have an auxiliary monitoring profile initiated to record trends in dosing history, pertinent laboratory values, microbiology results, pharmacokinetic analysis and additional comments.~~

~~4. Anticoagulants (i.e., heparin and warfarin) will be profiled on the Anticoagulation Worksheet.~~

~~a. Drugs with a narrow therapeutic index (i.e., aminoglycoside, vancomycin) will be profiled on the Therapeutic Drug Monitoring Worksheet.~~

~~b. Parenteral nutrition will be profiled on the Nutrition Support Services Worksheet.~~

Tri-City Medical Center
Oceanside, California

~~PHARMACY SERVICES POLICY MANUAL~~

DELETE - Some content obsolete (does not reflect current practice). Relevant content incorporated into Verbal and Written Orders Policy

~~ISSUE DATE: 6/12~~ ~~SUBJECT: Pharmacy Range Order Policy~~

~~REVISION DATE:~~ ~~POLICY NUMBER: 8390-3104~~

REVIEW DATE:

Department Approval:	05/15
Pharmacy & Therapeutics Committee Approval:	7/12, 05/15
Medical Executive Committee:	8/12, 06/15
Professional Affairs Committee:	07/15
Board of Directors:	8/12

~~A. PURPOSE:~~

~~1. To minimize errors in interpretation or administration of medications with a dose range.~~

~~B. POLICY STATEMENT~~

~~1. Medication orders that express the dose and/or dosing interval with a lower and upper limit are commonly referred to as "range orders." These orders are not only unclear and ambiguous, they are also a source for medication errors. Furthermore, the Joint Commission has stated that these orders are unacceptable unless a policy or protocol to interpret range orders is established (similar to a sliding scale insulin order). With a protocol in place for interpretation of range orders, the physician and nurse have the same understanding about patient treatment.~~

~~C. PROCEDURE~~

~~1. In order to provide appropriate pain management and facilitate timely administration of medications the lowest dose of any range order medication maybe repeated within 1 hr of original administration~~
   ~~a. This will automatically be entered by pharmacy for any range order as follows~~
   ~~b. Example 1-2 Percocet tablets every 4 hrs PRN will be entered by pharmacy as~~
      ~~i. 1 tablet of per Percocet every 4 hrs PRN, may repeat 1 tablet within 1 hr of administration~~

~~2. Range orders for a dosage that is more the double than smallest dose shall not be accepted by pharmacy and shall be clarified with the physician by pharmacy~~
   ~~a. Example Morphine 2-8 mg IV every 4 hrs PRN will be clarified by pharmacy~~
   ~~b. Acceptable orders include: Morphine 2-4 mg IV every 4 hrs PRN or Morphine 4-8 mg IV every 4 hrs PRN after speaking with the physician~~

~~3. The pharmacist shall enter these medications as "per protocol"~~

Tri-City Medical Center
Oceanside, California

DELETE, information contained in Pharmacy Antidote Stocking Policy

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 01/85~~ ~~SUBJECT: Poison Control~~

~~REVISION DATE: 07/06~~ ~~POLICY NUMBER: 8390-10001~~

Pharmacy & Therapeutics Committee Approval:	02/03, 07/06, 07/09, 1/12
Medical Executive Committee Approval:	02/03, 07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval	07/15
Board of Directors Approval:	02/03, 07/06, 07/09, 1/12

~~A. **POLICY**:~~
~~The hospital will use the services of the regional poison information center.~~

~~B. **PROCEDURE**:~~
~~1. Important Regional telephone numbers:~~
~~a. Poison Information Number: 1 (800) 876-4766~~
~~2. The regional poison information center is located: UCSD Medical Center~~
~~3. The telephone number of the regional poison information center will be posted on the telephones in all patient care areas.~~

DELETE - Content in Electronic, Verbal, and Written Orders- General Prescribing Pharmacy Policy, Automatic Therapeutic Interchange Pharmacy Policy, Patient Care Services Medication Administration Policy, and Patient Care Services Policy Physician Orders

Tri-City Medical Cent
Oceanside, California

PHARMACY~~POLICY~~ MANUA

~~ISSUE DATE: 01/80~~ ~~SUBJECT: Prescribing/Ordering – General Practices~~

~~REVISION DATE: 01/85, 04/90, 06/95, 07/06~~ ~~POLICY NUMBER: 8390-3002~~

Department Approval:	05/15
Pharmacy & Therapeutics Committee Approval:	02/03, 06/05, 07/06, 07/09, 1/12, 05/15
Medical Executive Committee Approval:	02/03, 06/05, 07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	02/03, 06/05, 07/06, 07/09, 1/12 [AMH1]

~~A. POLICY:~~

~~The hospital will develop, implement and maintain policies and procedures to support prescribing and ordering of drugs which ensure the safe, clear and legal use of drugs.~~

~~B. PROCEDURE:~~

~~1. All orders for medication and treatment must be legible.~~
~~2. Abbreviation: Medication orders shall contain only abbreviations and symbols, which have been approved by the medical staff.~~
~~3. Definitions: When used with medication orders:~~
~~4. Generic Substitution: For drug entities for which there are multiple sources, the Pharmacy Department will determine the source of medications for generic substitution. The Pharmacy and Therapeutics Committee may at its discretion determine the source for selected drugs and such information will be disclosed in the formulary. The physician may elect to not allow generic substitution by so stating in writing on the initial order.~~
~~5. Metric: Medication orders shall be written in metric notation only and shall avoid the use of a leading decimal, or a trailing zero.~~
~~6. PRN: Orders for "as needed" or "PRN" medications shall specify the indication(s) for use and be specific for dose and dosage frequency unless there is only one possible use for the medication (e.g., the only possible "as needed" use for a stool softener is the treatment of constipation).~~
~~7. Standard Administration Times: Unless otherwise specified, doses will be administered at the following times.~~ [AMH2]

~~a.~~

~~Sig~~	~~Administration Times~~
~~Daily~~	~~0900~~
~~Daily (warfarin)~~	~~1800~~
~~BID~~	~~0900, 1700~~
~~TID~~	~~0900, 1300, 1700~~
~~QID~~	~~0900, 1300, 1700, 2100~~
~~Q4H~~	~~0400, 0800, 1200, 1600, 2000, 2400~~
~~Q6H~~	~~0600, 1200, 1800, 2400~~
~~Q8H~~	~~0600, 1400, 2200~~
~~Q12H~~	~~0900, 2100~~
~~Nightly~~	~~2100~~

~~Sig~~	~~Administration Times~~
~~Daily~~	~~0900~~
~~Daily (warfarin)~~	~~1800~~

Sig	Administration Times
BID	0900, 1700
TID	0900, 1300, 1700
QID	0900, 1300, 1700, 2100
Q4H	0400, 0800, 1200, 1600, 2000, 2400
Q6H	0600, 1200, 1800, 2400
Q8H	0600, 1400, 2200
Q12H	0900, 2100
Nightly	2100

8. Therapeutic Substitution: Therapeutic substitution is allowed and the Pharmacy and Therapeutics Committee shall authorize such substitution and shall make the medical and nursing staff aware in the formulary and other publications.[AMH3]
9. There must be evidence of a diagnosis, condition or indication for use on the medical record for each medication ordered by the patient's licensed independent practitioner.
10. To be considered complete, all medication orders shall include the name of the drug, the dosage and strength, the quantity or duration (as appropriate), the route, rate and frequency of administration, the reason the drug is ordered/indications for usage (as appropriate) and the time and date the order is written. The patient's name must be documented on the order sheet, date, time of order and physician ordering the medications.
11. If the patient's age and weight and any known allergies or lack there of is not documented in the medical record at the time the order is written, the prescriber shall obtain these facts and document them with the written order.
12. Transfer Orders: When transferring a patient from one level of care to another, reviewing of orders will go as follows:
    a. All patients transferring from one level of care to another will have current orders reviewed as the physician will document any changes to previous orders that would be pertinent upon transfer within the physician transfer orders, to include but not limited to; from ACCU to IMC, IMC to ACCU, ACCU to Pavilion, IMC to Pavilion. See following examples:
        i. Physician documents patient to be transferred, "orders have been reviewed and no changes to be made." Physician times, dates and signs the order.
        ii. Physician documents patient to be transferred, with appropriate order(s) to be changed, an example such as, "orders have been reviewed, diet advanced to Soft Diet." Physician times, dates and signs the order.
    b. Minor invasive procedure, such as Endoscopy Procedure(s), Interventional Radiology Procedure(s), Lumbar Puncture(s), PICC Line Insertion(s), tracheotomies and Central Line Insertion(s) do not demonstrate transfer or the patient to new level of care.
    c. If Patient is transferring emergently to a different level of care to stabilize an EMC, the transferring physician will review, time, sign and date all transferring orders within twenty-four hours.
13. A Verbal Order: (noted in the chart as V.O) is defined as an order communicated by oral, spoken, face-to-face communication between the prescriber and authorized hospital personnel.
14. A Telephone Order: (noted in the chart as T.O.) is defined as an order communicated by telephone when the prescriber is not physically present (face-to-face) with the authorized personnel.
15. Verbal medication orders will only be accepted in emergency situations by a registered nurse or licensed pharmacist.
    a. Verbal orders given during patient procedures are to be recorded by the circulating nurse and signed by the ordering physician immediately following the procedure.
16. Telephone medication orders may be received by a registered nurse or licensed pharmacist. Verbal orders for drugs shall be given only to a registered nurse or licensed pharmacist by a person legally authorized to prescribe and shall be recorded in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or attending physician shall countersign the order within 48 hours.
    a. Elements of a telephone medication order that should be documented include:
        i. Name of patient
        ii. Age and weight of patient when appropriate
        iii. Drug name

iv. Dose, frequency and route
v. Quantity and duration
vi. Purpose or indication
vii. Name of prescriber, and telephone number when appropriate
viii. Name of individual transmitting order, if different from the prescriber. All entries into the medical/clinical/case record must be complete, accurate, and timely
ix. Complete medication orders contain the name of the drug, strength, dosage form, route of administration if other than oral, dosage regimen and preferably indication

b. All telephone orders must be documented immediately in writing and signed by the individual who received the order.
c. Telephone orders for antineoplastic agents are not permitted.
d. All verbal and/or telephone orders for medications shall include the following criteria:
i. Date and time the order is prescribed verbally or via telephone
ii. The name of the individual prescribing the drug and his/her licensure (i.e., MD, DPM)
iii. The generic *and* brand name of the drug
iv. Drug dosage (strength or concentration)
v. Quantity and/or duration
vi. Route drug is to be administered
vii. Frequency of administration
viii. Age and weight of the patient if this is not known, or in clinical circumstances where this is appropriate
ix. Known allergies (if this has not been determined at the time of the verbal/telephone order)
x. Specific indications for use, as appropriate
xi. Name and level of licensure of the individual receiving and documenting the order
xii. The entire telephone order is to be repeated back to the prescriber using the elements outlined above.[AMH4]

Tri-City Medical Center
Oceanside, California

DELETE - Incorporated in ControlledSubstance and Drug Distribution policies

PHARMACY ~~POLICY~~ MANUAL

~~ISSUE DATE: 05/94~~ ~~SUBJECT: Procurement of Medications~~[AMH1][AMH2]

~~REVISION DATE: 01/97, 08/00, 06/05, 07/06, 09/08~~ ~~POLICY NUMBER: 8390-2006~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**2/03, 06/05, 07/06, 09/08, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**2/03, 06/05, 07/06, 09/08, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**2/03, 06/05, 07/06, 09/08, 07/09, 1/12**

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

~~1. All drugs, biologicals, chemicals related to the practice of pharmacy, that is procured by the Pharmacy Department, shall meet the criteria as set forth in the United States Pharmacopeia or National Formulary or Federal Drug Administration requirements for drugs or found in the current literature as an extemporaneously used formula with valid cause.~~

~~2. The selection, distribution and safe and effective use of drugs at Tri-City Medical Center shall be established by the combined efforts of the Pharmacy Director, Pharmacy Department, medical staff and hospital administration.~~

~~3. These policies will be approved by the Pharmacy and Therapeutics Committee.~~

~~4. The drug supply shall contain that type and quantity of drugs necessary to meet the needs of the categories of patients that are serviced at Tri-City Medical Center as determined by the Pharmacy and Therapeutics Committee.~~

~~5. The Pharmacy Director and staff pharmacists shall be responsible for maintenance and the supply as well as assuring that all drugs are properly labeled and stored.~~

~~6. Factors to consider in purchasing a generic or brand name drug:~~

~~a. Bioavailability of drug~~
~~b. Reputation of manufacturer~~
~~c. Contract or non-contract price~~
~~d. Availability (local or distant)~~
~~e. Pharmacy and Therapeutics Committee recommendations~~

~~B. **PROCEDURE:**~~

~~1. Ordering:~~

~~a. Orders will be made by the Pharmacy Director or his/her designee. Orders are prepared daily and sent using the wholesaler computerized ordering system. Certain medications may be ordered directly from the manufacturer.~~

~~b. Schedule II medications shall be ordered on the required DEA form and signed by an authorized pharmacist.~~

~~c. A purchase order number is to be utilized with all direct purchases.~~

~~2. Receiving:~~

~~a. After the product is delivered directly to the Pharmacy or via Materials Management, the order will be checked against the packing slip and invoice. The Pharmacy copy of the purchase order is then checked against the packing slip/invoice. While verifying that the order is correct and all items arrived, any discrepancy should be noted and the order referred to the appropriate person.~~

~~b. The items will then be incorporated into the inventory. Utilize the wholesaler sticker if provided.~~

~~c. If the items received where not accompanied by an invoice, and thus unavailable for pricing, they will be put aside until an invoice is obtained and the items are able to be priced and placed into inventory.~~

~~d. If the order is complete, the pharmacist checking the order must initial and date the invoice or packing slip as an indication that the products were received. If not complete~~

notify buyer of discrepancy and buyer will contact the appropriate wholesaler for rectification.

e. Receipt of a Schedule II drug shall be checked against the original DEA order form and notations or date and quantity received should be made on the space provided by the Pharmacist.[AMH3]

f. *Upon delivery of a controlled drug the following procedure must occur:*

i. *The Director of Pharmacy or his designee (a pharmacist) will verify the receipt of all controlled drugs.*

ii. *The Pharmacist verifying the order with a technician will immediately log the controlled drugs into the C-II Safe.*

iii. *The pharmacist and the technician will sign the receipt generated by the C-II safe, verify the quantity listed on the C-II receipt to the quantity received by the pharmacist initially and the receipt will be attached to the controlled substance invoice.*

iv. *If there is a discrepancy noted in the delivered controlled substance from the wholesaler the driver delivering the controlled drug will initial the discrepancy, the pharmacist will note the discrepancy and the Director of Pharmacy or the Pharmacy Supervisor will be notified immediately of the discrepancy. The Director of Pharmacy or Pharmacy Supervisor will immediately notify the supervisor at the wholesaler company of the discrepancy.*[AMH4]

3. Invoices:

a. A copy of each invoice will be forwarded to Accounts Payable.

b. A copy of an invoice containing Schedule II drugs shall be stapled to the Pharmacy Department copy of the DEA order form and kept in a separate file.

c. Copies of invoices containing drugs in Schedules III, IV and V shall be kept in a separate file.

4. Damaged Goods, Shortages, Short-dated Items And Delivery Errors:

a. Damaged goods will be reported to the vendor and compensatory action will be taken to correct shortages and return any items that were received but not ordered.

5. Outdated Medications:

a. Outdated medications will be returned to the manufacturer after conferring with the company representative.

b. Outdated medications may also be returned through special drug return/disposal companies. (List the company of this type in your area here.) The Pharmacy Department utilizes "EXP Pharmaceutical Services Corporation" for returning of outdated products.

C. **LARGE VOLUME PARENTERALS:**

1. Procurement and Storage:

a. All large volume parenterals are procured from Materials Management Department.

b. Inventory replenishment is done electronically through the Materials Department.

2. Receiving:

a. All shipping cartons should be inspected immediately upon receipt for:

i. Water marks

ii. Signs of excessive abuse in handling (crushed or broken cartons)

b. Damaged cartons should be separated from the remainder of the shipment for inspection by a Pharmacist. The damaged carton should be returned to Materials Management who will attempt to obtain prompt replacement by the manufacturer.

c. Stock shall be rotated with the earliest expiration dated items to be used first.

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DELETE - All of this content covered in Pharmacist Order Verification and Drug Distribution Policy

PHARMACY ~~POLICY~~ MANUAL

~~ISSUE DATE: 01/85~~ ~~SUBJECT: Questionable Medication Orders~~

~~REVISION DATE: 03/06~~ ~~POLICY NUMBER: 8390-3106~~

Department Approval:	05/15
Pharmacy & Therapeutics Committee Approval:	06/05, 03/06, 07/09, 1/12[v1], 05/15
Medical Executive Committee Approval:	06/05, 03/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval:	07/15
Board of Directors Approval:	06/05, 03/06, 07/09, 1/12

~~A. POLICY:~~

~~1. A Pharmacist will contact the physician/nurse before dispensing a questionable medication order. Any questions or clarifications shall be directed either by oral or written communication. If the order is changed, the pharmacist will write the change in the patient's chart, sign and date the order.~~

~~2. Drug Allergies:~~

~~a. If a medication has been ordered that the patient has claimed an allergy to said medication or any of its constituents, the Pharmacist will hold the drug until such time as the Pharmacist may verify the order with the physician or the extent/type of allergy with the patient or patient's nurse.~~

~~b. A clinical intervention form shall also be completed by the Pharmacist if the patient is deemed allergic to the medication.~~

~~3. Drug Interactions:~~

~~a. In the event that a drug is ordered which may interact with another drug the patient is presently receiving, it will be the responsibility of the Pharmacist to notify the physician of such interaction if critical. If warranted by the Pharmacist's professional judgment, the order will be held until verification is received.~~

~~b. A clinical intervention form shall also be completed by the Pharmacist for verified interactions.~~

~~4. Questionable or Unclear Orders:~~

~~a. In the event that an order is received that is unclear or questionable, by nature of unusual dose, frequency, route, etc., it will be the responsibility of the Pharmacist to verify the order with the physician before dispensing. The Pharmacist may also request a nurse to clarify the order.~~

~~b. When resolved, the unclear order will be clarified in the physician's orders section of the chart by the physician, Pharmacist or nurse, in his/her own handwriting as a verbal order from the physician.~~

~~c. If the physician will not change the order to an approved regimen or provide reasonable documentation, the Pharmacist has a legal responsibility under state pharmacy law to refuse to provide the drug in question. The prescribing physician may decide to administer the drug himself/herself. Communications with the physician will be documented in the progress notes section of the medical record by the Pharmacist.~~

~~d. The Pharmacy and Therapeutics Committee Chairperson or Chief of Staff may be contacted to discuss the situation[v2].~~

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DELETE - Duplicate Content- Refer to Nuclear Medicine Radioactive Materials License Procedures Manual

PHARMACY ~~POLICY~~ MANUAL

~~**ISSUE DATE: 02/03**~~[AMH1] ~~**SUBJECT: Radioactive Medications**~~

~~**REVISION DATE: 03/06**~~ ~~**POLICY NUMBER: 8390-3116**~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 03/06, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**06/05, 03/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 03/06, 07/09, 1/12**

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

~~The procurement, storage, control, distribution and administration of radioactive medications and materials are the responsibility of the Imaging Department and the Radiology Service. Radioactive materials are supplied by vendor.~~

~~B. **PROCEDURE**:~~

~~1. Refer to Nuclear Medicine procedures:~~

~~a. Ordering, Receipt and Documentation of Radioactive Materials~~
~~b. Storage of Radioactive Materials~~
~~c. Radioactive Waste Disposal~~
~~d. Rules Regarding Administration of Radioactive Materials~~
~~e. Dosage of Radioactive Materials~~

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PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: **10/10** **SUBJECT:** **Restricted Antimicrobials**

REVISION DATE: ~~**3/15**~~ ~~**POLICY NUMBER: 8390-6019**~~

Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**10/10, 03/15**
Medical Executive Committee Approval Date(s):	**10/10, 06/15**
Professional Affairs Committee Approval Date(s):	**07/15**
Board of Directors Approval Date(s):	**10/10**

A. **PURPOSE:**

1. To **provide a list of restricted antimicrobials where prescribing of such medications is limited to specific indications or medical specialty in order to improve clinical outcomes, reduce rates of emerging resistance, and reduce the incidence of adverse events.** ~~limit the use of restricted antimicrobials to the treatment of infections caused by multi-drug resistant organisms, patients with multiple drug allergies or contraindications to first line agents~~.
2. **To provide restriction criteria and outline requirements for prescribing and dispensing of restricted antimicrobials**
3. **To provide a process that streamlines the approval of restricted antimicrobials**

~~2. To minimize the development of microbial resistance.~~
~~3. To reduce the incidence or likelihood of adverse effects of antimicrobial use.~~

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

~~1. The Restricted Antimicrobial List is comprised of antimicrobials which if overused could lose their activity against multiple drug-resistant organisms (MDRO). The list also includes agents with known serious adverse effects which would require close monitoring and dosage adjustment by Infectious Disease specialists.~~

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

1. ~~Standards of Practice:~~ **Restriction criteria shall be reviewed and revised at least annually by Pharmacy and the Infectious Disease (ID) Physician based on usage patterns, microbiology data, and cost-effective analyses.**

~~a.~~**2.** **Restriction Criteria shall be approved by** ~~The~~ **the** Pharmacy & Therapeutics **(P&T)** committee. ~~establishes the Restricted Antimicrobial List based on the hospital antimicrobial formulary. The committee will review, revise, and approve the Restricted Antimicrobial List as may be required.~~

   a. **Use of antimicrobials that do not meet criteria shall require ID approval.** ~~The Pharmacy & Therapeutics Committee reviews the usage patterns of restricted antimicrobials at their quarterly meetings.~~ [e1]
   b. **The Infectious Disease Physician shall collaborate with those** ~~Physicians~~ who fail to comply with the restriction guidelines **set forth by P&T.** ~~are counseled individually the Chair of the Pharmacy & Therapeutics Committee.~~

   ~~Medical specialties can petition the Pharmacy & Therapeutics Committee to have restricted antimicrobials prescribed by members of their specialty, e.g. inhaled tobramycin for the pulmonologists, rifaximin for the gastroenterologists, etc.~~

~~2.~~**3.** **All restrictions apply to inpatient and emergency room patients with the exception of patients enrolled in investigational antibiotic drug studies.**

C. **PROCEDURE:** ~~Steps of Procedure~~:

1. The clinical pharmacist and/or Pharmacy Clinical Manager -**shall** -**review** all requests for restricted antimicrobials.
2. If the patient meets criteria for use of the agent **(see Antimicrobial Agents Requiring Approval: Criteria For Use~~Attachment 1~~),** the clinical pharmacist will approve the request.
3. **If the patient fails to meet criteria, the prescriber will be notified that continued use of restricted antimicrobials requires approval by the Infectious Disease Physician.** ~~If the patient fails to meet criteria, the clinical pharmacist will recommend an alternate agent that does not require ID or specialty approval.~~
4. If **the** ~~physician~~ **prescriber** insists on using a restricted antimicrobial, ~~he/she will be asked to obtain an Infectious Disease consult. The ID specialist will determine if the antimicrobial is indicated.~~ **the patient will be provided with enough doses (i.e. up to 24 hours, or through the weekend) to allow enough time for the prescribing physician to contact the Infectious Disease Physician and obtain approval. The prescriber will be notified of how many doses will be dispensed pending approval.**
5. **The Infectious Disease Physician will determine if the antimicrobial is indicated and provide approval if continued use of restricted antimicrobial is deemed appropriate.**
6. **The Infectious Disease physician shall notify pharmacy regarding status of approval.**

~~i.~~**7.** **If the antimicrobial is approved by the Infectious Disease Physician, the pharmacist shall update the order comments, otherwise the order shall be discontinued by the prescriber.**

~~D. If the physician continues to insist on using a restricted antimicrobial without an ID consult, then the Pharmacy will fill the request for a restricted antimicrobial, dispensing enough doses until the morning of the next day. The prescribing physician will be asked to obtain an ID consult by the next day.~~

D. **FORMS/RELATED DOCUMENTS:**

1. **Antimicrobial Agents Requiring Approval: Criteria For Use~~Attachment 1: Restriction Antimicrobial List~~**

~~See attached.~~

~~RESTRICTION ANTIMICROBIAL LIST~~

~~March 25, 2010~~

ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

~~1. Ceftazidime (Fortaz®) - Third-generation cephalosporin that retains activity to Pseudomonas aeruginosa. Implicated in increased risk for C. difficile and increased risk for extended spectrum beta-lactamase (ESBL) production. Restricted to documented Pseudomonas aeruginosa (PSA) infections (any prescriber) Empiric therapy restricted to Oncologists, Pulmonology, Critical Care, or Infectious Disease specialists.~~

1. **Ceftazidime (Fortaz®)**
    a. **For treatment of documented *Pseudomonas aeruginosa*, *Serratia* or *Acinetobacter* species (any prescriber)**
    b. **Empiric therapy restricted to Oncologists, Pulmonology, Critical Care, or Infectious Disease specialists**

~~2. Cefepime (Maxipime) – Fourth-generation cephalosporin that retains activity to PSA. Prolong use may result in bacterial or fungal super infection. Restricted to documented PSA infections (any prescriber). Empiric therapy restricted to Pulmonology, Critical Care, or Infectious Disease specialists.~~

2. **Cefepime (Maxipime)**
    a. **For treatment of documented *Pseudomonas aeruginosa*, *Serratia* or *Acinetobacter* species (any prescriber)**
    b. **For empiric treatment of febrile neutropenia (any prescriber)**
    c. **Empiric therapy restricted to Oncologists, Pulmonology, Critical Care, or Infectious Disease specialists**

3. Amikacin & Tobramycin - Aminoglycoside antibiotics that retain activity to PSA.

~~3.~~ **a.** Restrict tobramycin**/amikacin** to documented or highly suspected PSA infections **or other MDRO pathogen**(any ~~prescriber). Restricted amikacin to Infectious disease, Pulmonology, and Critical Care specialists.~~

~~[e2]~~

~~4. Aztreonam (Azactam®) - Restricted to B-lactam allergic patients for treatment of documented PSA infections in combination with another antipseudomonal antibiotic. Including pneumonia patients in ICU with a penicillin allergy or pneumonia patients with penicillin allergy and Pseudomonas is a consideration (any prescriber).~~

4. **Aztreonam (Azactam®)**
    a. **For treatment of gram negative infections in patients with a documented allergic reaction to pencillins or cephalosporin (any prescriber)**
        i. **Monotherapy should be used only when cultures and sensitivities have been reported.**
    b. **For empiric treatment of febrile neutropenia in a patient with anaphylactic allergy to penicillin (any prescriber)**

~~5. Linezolid (Zyvox®) – Restricted to documented VRE infections (any prescriber). Empiric therapy restricted to Infectious Disease, Critical Care, or Pulmonology specialists.~~

5. **Linezolid (Zyvox®)**

a. For treatment of documented serious infections (except involving the urinary tract) with confirmed vancomycin resistant *Enterococcus faecalis/faecium* (any prescriber)
b. Empiric therapy or UTI restricted to Pulmonology, Critical Care, or Infectious Disease specialists

~~6. Quinupristin/ Dalfopristin (Synercid®) – Non-Formulary agent restricted to documented VRE infections prescribe only by Infectious disease, Pulmonology, and Critical Care specialists.~~

6. Quinupristin/ Dalfopristin (Synercid®)
   a. For treatment of documented serious infections with confirmed vancomycin resistant *Enterococcus faecium* only (restricted to Infectious Disease Physician only and Pharmacy Clinical Manager approval)
      i. Patient must have a central line
      ii. *Enterococcus faecalis* is inherently resistant to quinupristin/dalfopristin

~~7. Meropenem (Merrem®) – Restricted to documented Acinetobacter infections (any prescriber). Empiric therapy restricted to Pulmonology, Critical Care, and Infectious Disease specialists.~~

7. Meropenem (Merrem®)
   a. For treatment of serious infections due to documented multi-drug resistant gram negative bacilli that are only sensitive to the carbapenem class of antibiotics (any prescriber).
   b. For treatment of extended-spectrum beta-lactamase (ESBL) producing *Enterobacteriacae.*
   c. Empiric therapy restricted to Oncologists, Pulmonology, Critical Care, or Infectious Disease specialists.
   d. NOT indicated for necrotizing pancreatitis (recommend piperacillin/tazobactam for this indication).

~~8. Voriconazole (V-Fend®) - Restricted to documented Aspergillosis infections or non-albicans candida infections (any prescriber). Empiric therapy or non-Aspergillosis infections restricted to Pulmonology, Critical Care, and Infectious Disease specialists.~~

8. Voriconazole (V-Fend®)
   a. For treatment of documented invasive aspergillus infections (any prescriber)
   b. Treatment of probable mold infections (exception: NOT indicated for Zygomycetes)
   c. Empiric therapy or other fungal infections is restricted to Pulmonology, Critical Care, or Infectious Disease specialists.

~~9. Caspofungin (Cancidas®) - Restricted to documented Aspergillosis infections (any prescriber). Empiric therapy or non-Aspergillosis infections restricted to Pulmonology, Critical Care, and Infectious Disease specialists.~~ [e3]

9. Micafungin (Micamine®)
   a. For treatment of documented non-albicans candidemia (any prescriber)
   b. Empiric therapy of febrile neutropenia (any prescriber)
   c. Other empiric therapy is restricted to Pulmonology, Critical Care, or Infectious Disease specialists

~~10. Doripenem (Doribax®) & Imipenem (Primaxin®) – Restricted formulary Carbapenems antibiotics that retain activity to Resistant Gram Negative bacteria. Restricted to Pulmonology, Critical Care, and Infectious Disease specialists.~~

10. Doripenem (Doribax®) & Imipenem (Primaxin®)
    a. Restricted to Infectious Disease Physician and Pharmacy Clinical Manager approval.

~~11. Daptomycin (Cubicin®) – Restricted formulary agent restricted to Pulmonology, Critical Care, and Infectious Disease specialists.~~

11. Daptomycin (Cubicin®)

a. **For treatment of documented bacteremia with confirmed vancomycin resistant Enterococcus faecalis/faecium or treatment of any other documented vancomycin-resistant Enterococcus faecium infections except lung or UTI (any prescriber)**
b. **Empiric therapy is restricted to Pulmonology, Critical Care, or Infectious Disease specialists.**

~~12. Tigecycline (Tygacil®) – Restricted formulary agent restricted to Pulmonology, Critical Care, and Infectious Disease specialists~~

12. Tigecycline (Tygacil®)
a. **Non-formulary agent restricted to Infectious Disease Physician**

13. Ceftaroline (Teflaro®)
a. **Restricted to Infectious Disease Physician only and Pharmacy Clinical Manager approval**

14. Dalbavancin (Dalvance®) & oritavancin (Orbactiv®)
a. **Non-formulary agent restricted to Infectious Disease Physician only and Pharmacy Clinical Manager**
b. **Doses should not be administered unless ordered by Infectious Disease Physician**

~~* All of the above restrictions apply to inpatient and emergency room dosing with the exception of patients enrolled in investigational antibiotic drug studies.~~

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DELETE - Content covered in Patient Care Services Medication Administration Policy

PHARMACY~~POLICY~~ MANUAL

~~ISSUE DATE: 09/91~~[AMH1] ~~SUBJECT: Self Administration of Medications by Patients and Non Staff Members~~

~~REVISION DATE: 01/97, 07/00, 04/05, 07/06, 1/12~~ ~~POLICY NUMBER: 8390-5102~~

Department Approval Date(s):	05/15
Pharmacy & Therapeutics Committee Approval:	04/05, 07/06, 07/09, 1/12, 05/15
Medical Executive Committee Approval:	04/05, 07/06, 07/09, 1/12, 6/15
Professional Affairs Committee Approval Date(s):	07/15
Board of Directors Approval:	04/05, 07/06, 07/09, 1/12

~~A. POLICY:~~

~~1. Medications will be self-administered only on the specific written order of the attending physician.~~
~~2. Persons who administer medications, but are not staff members (including the patient if self-administering), must demonstrate ability to safely administer medication before being allowed to self-administer medications.~~
~~3. All teaching is documented in the Patient Care Record.~~
~~4. Nursing will document all self-administered doses on the Medication Administration Record.~~

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PHARMACY~~POLICY~~ MANUAL

DELETE – no longer required, this is drug information which is covered in the Pharmacy Antidote Stocking Policy

~~**ISSUE DATE: 05/02**~~ ~~**SUBJECT: Succimer (Chemet) in Lead Poisoning**~~

~~**REVISION DATE: 07/06**~~ ~~**POLICY NUMBER: 8390-10014**~~

Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval:	**02/03, 07/06, 07/09, 1/12, 03/15**
Medical Executive Committee Approval:	**02/03, 07/06, 07/09, 1/12, 6/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**02/03, 07/06, 07/09, 1/12**

A. ~~**PURPOSE**:~~
~~To provide information and dosing guidelines for the use of Succimer (Chemet) in the management of acute lead poisoning or lead encephalopathy.~~

B. ~~**GENERAL INFORMATION**: Succimer is an oral chelating agent used for lead poisoning of children > 1 year of age. No data are available on the concomitant use of Succimer, edetate calcium disodium (EDTA) and or dimercaprol (BAL) and such use is not recommended by the manufacturer:~~
1. ~~Edetate calcium disodium (EDTA) used in combination with dimercaprol (BAL) is available as an alternate therapy for lead poisoning.~~
2. ~~Penicillamine is also effective as oral therapy for long-term therapy of lead intoxication~~

C. ~~**DOSING GUIDELINES**:~~
1. ~~For the treatment of lead poisoning in children with blood levels > 45 mcg/deciliter, the initial oral dose of Succimer is 10mg/kg or 350mg/square meter every 8 hours for 5 days, then 10mg/kg or 350mg/square meter every 12 hours for 14 days. A total course of therapy is 19 days.~~
2. ~~Courses of therapy may be repeated if indicated by weekly monitoring of blood lead concentrations; lead concentrations should be stabilized below 15 mcg/deciliter. Two weeks between courses is recommended, unless lead levels indicate a need for more timely treatment. Adequate hydration should be maintained throughout therapy.~~
3. ~~In children unable to swallow capsules, the capsules may be separated and the contents sprinkled onto a small amount of soft food or put into a spoon to be followed by a fruit drink. No data are available regarding the use of Succimer in children under 1 year of age.~~
4. ~~As with all chelating agents, rebound elevations in blood lead levels and associated symptoms may occur after treatment due to redistribution of lead from bone; monitoring of blood lead levels should be performed periodically. Succimer is eliminated renally, and should be administered with caution in patients with renal impairment.~~
5. ~~Adverse effects reported include: increased LFT's, nausea/vomiting, rash, diarrhea, and neutropenia.~~

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PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 10/07

SUBJECT: Technician Checking Technician Program

REVISION DATE: 07/09, 11/09, 5/15

~~**POLICY NUMBER: 8390-10022**~~

Department Approval:	**0515**
Pharmacy & Therapeutics Committee Approval:	**10/07, 07/09, 1/12, 05/15**
Medical Executive Committee Approval:	**10/07, 07/09, 1/12, 6/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**10/07, 07/09, 1/12**

A. **POLICY**:

1. A general acute care hospital, as defined in Health and Safety code 1250(a), that has an ongoing clinical pharmacy program may allow pharmacy technicians to check the work of other pharmacy technicians in connection with the filling of floor and ward stock and unit dose distribution systems for patients admitted to the hospital whose orders have previously been reviewed and approved by a licensed pharmacist.
2. Only inpatient hospital pharmacies as defined in 4029(a) that maintain a clinical pharmacy services program as described in 4052 may have a technician checking technician program as described. The pharmacy shall have on file a description of the clinical pharmacy program prior to initiating a technician checking technician program. The overall operation of the program shall be the responsibility of the pharmacist-in-charge.
3. This section shall only apply to acute care inpatient hospital pharmacy settings.
4. Hospital pharmacies that have a technician checking technician program shall deploy pharmacists to the inpatient care setting to provide clinical services.

B. **PROCEDURE**:

1. To ensure quality patient care and reduce medication errors, programs that use pharmacy technicians to check the work of other pharmacy technicians must include the following components:
2. Compounded, repackaged or non-scanned products must have been previously checked by a pharmacist and then may be used by the technician to fill unit dose distribution systems, and floor and ward stock.
3. The pharmacist(s) on duty will be responsible for answering any questions or handling any issues a technician may have with regards to tech check tech program.
4. Every technician will have their work checked by another technician when filling any non-compounded or non-repackaged medication for distribution to Automated Dispensing Cabinets or for distribution to other medication storage areas.
5. All technicians will **be given** ~~receive~~ **a written test (Pharmacy Tech Competency** Test**) on an annual, ongoing basis.** ~~one on one training by the Pharmacy Technician Supervisor. At the end of the training period a final check will be conducted for accuracy of filled products. 100% filling accuracy will be the standard and if the standard is not met additional training will occur.~~

~~6.A "Filling Discrepancy Log" (attached to Policy) will be utilized by the checking technician. Anytime an incorrect medication is filled the checking technician will fill out the log with requested information. Filling discrepancies will be evaluated and reviewed for problems and trends.~~

~~7.~~**6.** A Competency review form will be signed by the technician and qualified evaluator upon completion of the **written test.**~~training.~~

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PHARMACY~~POLICY~~ MANUAL

DELETE - Duplicate policy. Covered in Anticoagulation Dosing Procedure, Vanco and Aminoglycoside Dosing and Monitoring Procedures, Automatic Renal Dose Adjustment Procedure

~~**ISSUE DATE: 05/92**~~ ~~**SUBJECT: Therapeutic Drug Monitoring**~~

~~**REVISION DATE: 10/94, 09/96, 04/97, 04/99, 04/02, 02/03, 07/06,1/12**~~ ~~**POLICY NUMBER: 8390-6003**~~

Department Approval:	**05/15**
Pharmacy & Therapeutics Committee Approval:	**06/05, 07/06, 07/09, 1/1205/15**
Medical Executive Committee Approval:	**06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval:	**07/15**
Board of Directors Approval:	**06/05, 07/06, 07/09, 1/12**

~~A. **POLICY**:~~
~~The Pharmacy and Therapeutics Committee will authorize pharmacists to manage and monitor the therapy of approved drugs according to protocol. The pharmacists are authorized to initiate and/or modify the therapy of these drugs if requested by the patient's physician.~~

~~B. **PROCEDURE**:~~
~~1. Upon written request by the physician, the clinical pharmacist will assist with the dosing and dosage adjustment of the following drugs under protocol (see specific sections) as approved by the Medical Staff through the Pharmacy and Therapeutics Committee:~~
~~a. Aminoglycosides Protocol (20.5)~~
~~i. Amikacin~~
~~ii. Gentamicin~~
~~iii. Tobramycin~~
~~b. Vancomycin Protocol (20.6)~~
~~c. Vancomycin Protocol Special Populations (20.7)~~
~~d. Renally Excreted Drugs (Renal Insufficiency Dosing Service 20.8)~~
~~e. Anticoagulation Dosing Service (20.9)~~
~~i. Heparin~~
~~ii. Warfarin~~
~~2. All clinical pharmacists providing these services shall have continuous competency evaluation by the Pharmacy Clinical Specialist. Some of the above listed activities may require completion of a certification procedure or competency module and/or examination prior to their participation. All pharmacists are responsible for the *Completion of Therapeutic Drug Monitoring Profiles (20.14)*~~
~~3. Upon receipt of an order written by an attending physician, the pharmacist may initiate/modify a protocol drug regimen and order appropriate laboratory tests to monitor said regimen according to protocol as set forth by the Pharmacy and Therapeutics Committee.~~
~~4.~~

~~**PROCEDURE**~~	~~**RESPONSIBILITY**~~
~~a. Chart order for "Pharmacy Consult" or like order.~~	~~Physician~~
~~b. Assessment of patient-specific parameters and laboratory values necessary for dosage/interval calculation.~~	~~"Certified" Registered Pharmacist~~
~~c. Calculate dose/interval.~~	~~"Certified" Registered Pharmacist~~
~~d. Consult physician as necessary.~~	~~"Certified" Registered Pharmacist~~
~~e. Write orders per protocol for:~~ ~~i. dose/interval~~ ~~ii. serum drug levels as needed~~ ~~iii. other protocol labs as needed~~ ~~iv. patient weight & height as needed~~	~~"Certified" Registered Pharmacist~~
~~f. Review progress notes and orders written by pharmacist within 24 hours.~~	~~Physician~~

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PHARMACY~~POLICY~~ MANUAL

ISSUE DATE:	**11/93**	**SUBJECT:**	**Unlabeled Uses of FDA-Approved Medications**
REVISION DATE:	**05/97, 08/00, 06/05, 07/06, 3/15**	**~~POLICY NUMBER: 8390-2007~~**	

Department Approval Date(s):	**03/15**
Pharmacy & Therapeutics Committee Approval Date(s):	**12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06, 07/09, 1/12, 03/15**
Medical Executive Committee Approval Date(s):	**12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06, 07/09, 1/12, 06/15**
Professional Affairs Committee Approval Date(s):	**07/15**
Board of Directors Approval Date(s):	**12/93, 6/96, 9/99, 9/01, 02/03, 06/05, 07/06, 07/09, 1/12**

A. **DEFINITIONS**:

1. For purposes of this policy "unlabeled use" includes the use of a drug product in (1) doses, (2) patient populations, (3) indications, (4) routes of administration that are not reflected in FDA-approved product labeling.

B. **POLICY**:

~~1. **The following policy is in effect for both Pharmacy and Nursing Departments:**~~

~~2.~~**1. Pharmacy shall consider the off-label use of FDA approved drugs as prescribed by a physician to treat chronic, disabling, or acute, life-threatening illnesses medically necessary when:**

- a. **The drug has been approved by the FDA for at least ONE indication AND**
- b. **The drug is listed in a standard drug reference compendium for the off-label indication, such as:**
  - i. **The United States Pharmacopoeia Drug Information (USPDI)**
  - ii. **American Hospital Formulary Drug Information (AFHS-DI)**
  - iii. **National Comprehensive Cancer Network (NCCN)**
  - iv. **Thompson Micromedex DrugDex**
  - v. **Lexicomp**
  - vi. **Clinical Pharmacology**

  OR,
- c. **The off-label use is supported substantially by accepted peer-reviewed medical literature**

~~3. A physician may order a medication for an unlabeled use at Tri-City Medical Center, provided such use is documented in the AHFS Drug Information or the Micromedex® Drugdex® drug monographs as safe and effective.~~

2. Off-label use of a drug shall not be considered if the FDA has determined said use to be absolutely contraindicated.

~~4.~~**3.** If the unlabeled use is not identified in the aforementioned compendia, the physician must present a proposal for said unlabeled use, along with documentation of safety and efficacy, to the Pharmacy and Therapeutics Committee at Tri-City Medical Center for approval.

~~5.~~**4.** If the physician insists upon immediate use of a medication for unlabeled use not identified in the aforementioned compendia, the pharmacist will contact the physician for information regarding off label use **and seek approval from the Clinical Manager**. If information supporting off label use is verified by **pharmacy, the electronic medication order will be verified by the** pharmacist~~, a~~

~~chart order will be written by pharmacist~~ for immediate administration of the drug by nursing personnel.

~~6.~~**5.** If there is disagreement between the pharmacist and the prescribing physician, the Chairman of the Pharmacy and Therapeutics or his/her designee must be contacted for approval.

~~7.~~**6.** If the Pharmacy and Therapeutics Chairman is unavailable, the chain of command is as follows:

a. Division Chief
b. Department Chairman or Vice-Chairman
c. Chief of Staff

~~8.~~**7.** Once a decision is made regarding **the** "unlabeled use" of a medication by ~~physician ordering the off label use of a drug and~~ the Chairman of the Pharmacy and Therapeutics Committee, or Division Chief, or Department Chairman, or Department Vice-Chairman, or Chief of Staff, the decision is final.

~~9.~~**8.** The decision will be communicated to the Pharmacy Department, and documentation in the chart will be noted by the pharmacist regarding the final decision.

Tri-City Medical Center
Oceanside, California

PHARMACY~~POLICY~~ MANUAL

ISSUE DATE: 04/77

SUBJECT: Unusable ~~and Outdated Drugs~~Medications

REVISION DATE: 06/05, 07/06, 03/15

~~POLICY NUMBER: 8390-4602~~

Department Approval Date(s):	03/15
Pharmacy & Therapeutics Committee Approval Date(s):	06/05, 07/06, 07/09, 1/12, 03/15
Medical Executive Committee Approval Date(s):	06/05, 07/06, 07/09, 1/12, 06/15
Professional Affairs Committee Approval Date(s)	07/15
Board of Directors Approval Date(s):	06/05, 07/06, 07/09, 1/12

~~A. POLICY:~~

~~1. All discontinued patient drugs; outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels shall be returned to the Pharmacy Department for proper disposal. These drugs shall be stored in an isolated area in the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs shall remain there until they can be returned to the manufacturer or proper disposal or pick up can be made.~~

~~2. Drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act shall be destroyed or shipped to the approved agencies for destruction according to current state and federal laws.~~

~~B.~~A. PROCEDURE:

1. All ~~drug~~ **medication** storage areas of the hospital will be inspected~~, including satellite pharmacies; Surgery, and other patient care unit stock areas if applicable,~~ for outdated ~~drugs~~, contaminated ~~drugs,~~ improperly stored ~~drugs~~ **medications** and containers with worn, illegible or missing labels. The Pharmacy staff member conducting the inspection will remove all of these types of ~~drugs~~ **medications** from the area.
2. **The medication storage areas will be inspected by a pharmacist, pharmacist intern, or pharmacy technician on a monthly basis.**
   a. **The nurse manager or designee will be notified of the inspection findings at the time the inspection is complete.**
   b. **If the inspection is performed by a pharmacist intern or pharmacy technician, any irregularities found during an inspection will be reported to the Director of Pharmacy or designee within 24 hours.**
3. **Nursing, or other staff approved by license to administer medications, who note outdated, contaminated, improperly stored medications or containers with worn, illegible or missing labels, will contact the Pharmacy Department to notify them of the drug's existence on his or her unit. Pharmacy personnel will remove the medication from the unit.**
   a. **Patient specific medications that are used should be placed in the appropriate waste bin on the nursing unit at the time of patient discharge or discontinuation of the physician order.**
4. **Unusable medications shall be stored in an isolated area within the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs shall remain there until they can be returned to the manufacturer or picked up by the pharmaceutical reverse distribution company.**
5. **A record of medications returned to the manufacturer or pharmaceutical reverse distribution company will be maintained. Documentation will include the name of the receiving company, the name, strength and quantity of medications, and the date the medications were removed from the Pharmacy Department.**

6. Medications that are to be disposed of within the pharmacy department will be done according to current regulations.

~~1.~~**7. Disposal of controlled substances within the pharmacy department must be done in the presence of two (2) witnesses, one of which must be a pharmacist. A record of all controlled substances that are disposed of within the Pharmacy Department will be maintained for three (3) years. The record will consist of the name and strength of the medication, quantity, signatures of witnesses, and date of destruction.**

~~a. Nursing or other staff approved by license to administer medications, noting outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels, will contact the Pharmacy Department notifying that department of the drug's existence on his or her unit. Pharmacy personnel will contact floor and remove medication.~~

8. Medications from outside the hospital brought in by patients and left in the Pharmacy Department for- storage greater than 30 days:

~~2.~~**a. Will be destroyed in accordance with current regulations.**

b. ~~Shall be logged for~~ **A record of** -disposal **will be noted on** ~~in~~ the "Patient's Own Medication ~~Log~~**Record**".

~~a.~~**c. Upon destruction, the information on the "Patient's Own Medication Record" will include the name of medication, strength, quantity if a controlled substance, patient's name, date of destruction and signature of person(s) disposing of the medication(s).**

~~b.~~**d.** Controlled substances ~~brought in by the patient~~ shall be ~~logged for destruction~~ **destroyed** in the presence of two (2) pharmacists. ~~The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of witnesses shall be recorded on the "Patient's Own Medication Log".~~

~~c.~~**e.** The records shall be kept for three (3) years.

~~3. Any medications that are identified and returned as unusable or that were brought in by a patient and not claimed within 30 days after discharge, shall be either returned to the manufacturer or discarded in designated containers for pick up and destruction by the approved disposal company.~~

~~a. Unusable drugs may be returned to the manufacturer for credit dependent upon the manufacturer's policies and the type of medication itself.~~

~~i. Medications that may be returned to the manufacturer will be returned per the manufacturer's instructions.~~

~~ii. Medications that are to be disposed will be sequestered and placed in the approved area of the Pharmacy Department designated for disposal company retrieval or manufacturer return.~~

~~2. A record of removal from the facility will be kept with documentation on the unusable drug final disposal record, which includes the name of the disposal company, the name, strength and quantity of medications for disposal, reason for disposal and the date and time the medications were removed from the Pharmacy Department.~~

~~3. The "Patient's Own Medication Log" shall be used for documenting the disposal of medications brought in by patients.~~

DIAGNOSIS: _____

ALLERGIES: _____

ADMIT STATUS: ☐ Inpatient ☐ Observation

ADMIT TO: ☐ Pre-Op Hold

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

DIET:
- ☐ NPO after midnight
- ☐ NPO after _____AM or _____PM

SURGICAL PROCEDURE / CONSENT FORM TO READ: _____
_____
_____

LAB/DIAGNOSTICS:
- ☐ CBC
- ☐ PT/PTT
- ☐ C7
- ☐ C12
- ☐ Capillary blood glucose (finger stick if diabetic)
- ☐ Urinalysis:
  - ☐ Routine
  - ☐ Microscopic
  - ☐ C&S if greater than 5 WBC/HPF
  - ☐ HCG, **Urine**
  - ☐ **HCG , Serum * Note: Indicated for women of childbearing age (women greater than 55 years) or no documented instance of bilateral tubal ligation, bilateral oophorectomy, hysterectomy**
- ☐ K^+ AM of surgery if on dialysis
- ☐ Type & Rh
  - ☐ Type & Screen
  - ☐ **Provide patient with copy of *Patient's Guide to Blood Transustions***
  - ☐ Sign Blood Transfusion/Refusal Consent
- ☐ Type and cross for: _____ units
  - ☐ Random Units
  - ☐ Donor Specific
  - ☐ Autologus, if available

Has patient received transfusion in last 3 months? ☐ Yes ☐ No
Has patient been pregnant within the last 3 months? ☐ Yes ☐ No
- ☐ Other: _____

Labs to be done at: _____ **Send results to TCMC or Fax to (760) 940-4059**
- ☐ ECG~~,~~ **Pre-Op if greater than 60 years of age, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or renal disease**~~Pre-Op for males over 40 years of age or relevant history, females over 50 years of age or relevant history~~
- ☐ **May use recent** ECG, **(done within the last six months)** ~~Pre-Op for females over 50 years of age or relevant history~~
- ☐ Chest X-Ray, Pre-Op ~~over 60 years of age or relevant history~~**: if evidence of acute cardiopulmonary condition by H&P, or >70 with chronic cardiopulmonary condition and no CXR within past six months.**
- ☐ X-Rays to be pulled for the case: _____

Nurse's – Initial_____

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INPATIENT PRE-SURGICAL
AM ORDERS
Page 1 of 3

Where X-Rays to be done: _____

IV:

- ☐ ~~Buffered~~ Lidocaine 1% 0.2mL intradermal for IV insertion pre-op.
  ~~***Note: For Buffered Lidocaine preparation: : remove and discard 2 mL of Lidocaine from 20 mL bottle of 1% Lidocaine and add 2 mL of sodium bicarbonate 8.4% to 20 mL vial of 1% Lidocaine**~~
- ☐ Start IV with 16-20 gauge catheter with Lactated Ringer's 1000 mL at 20 mL/hr rate
- ☐ Other: _____

MEDICATIONS:

- ☐ Fleets enema X_____ ☐ H.S. ☐ In AM of surgery (At Home)
- ☐ Cefazolin[e1] ~~1~~ 2grams (IVPB) attach to chart; to be administered ~~within 30 minutes~~**prior to** ~~of~~ incision
- ☐ **Cefazolin 3 gram (if> over 100kg)**[e2] **(IVPB) attach to chart; to be administered prior to incision**
- ☐ Gentamicin_____mg (IVPB) attach to chart; to be administered ~~within 30 minutes of~~**prior to** incision
- ☐ Cefotetan 2 grams (or Cefoxitin[e3] 2 grams if Cefotetan is unavailable) (IVPB) attach to chart; to be administered ~~within 30 minutes of~~**prior to** incision
- ☐ **Cipro 400mg (IVPB) attached to chart, to be administered prior to incision**
- ☐ **Levaquin, _____mg (IVPB) attach to chart to be administred prior to incision**
- ☐ **Vancomycin, 1 GM** [e4]**(IVPB) attach to chart to be administered**[e5] **prior to incision**
- ☐ Pre-op Beta-Blocker
  - ☐ If patient routinely on Beta-Blocker, pre-operatively, verify date and time of last dose taken. Document on MAR.
  - ☐ If Beta-Blocker last dose not taken within 24 hours, patient to take _____ (medication and dose) with sip of water upon arrival to pre-op hold/surgery.
- ☐ Other: _____

~~**DVT PROPHYLAXIS:**~~

~~**Conditions:**~~

- ~~☐ No additional DVT Prophylaxis required at this time~~
- ~~☐ DVT Anticoagulation Prophylaxis contraindicated.~~
  ~~Explain: _____~~

~~**Caution if using this Protocol for Prescribing Heparin or Enoxaparin if Platelets < 100,000/mcL.**~~

~~**Non-Medication DVT Prophylaxis:**~~

~~☐ Sequential compression device ☐ Thigh high ☐ Knee high~~
~~€ Bilateral € Right € Left~~

- ~~☐ Thigh-high graduated compression stockings~~
- ~~☐ Knee-high graduated compression stockings~~

~~**Moderate To High Risk (Including general surgery, hip fracture surgery, total hip replacement, and total knee replacement):**~~

- ~~☐ Enoxaparin (Lovenox) 30 mg subcutaneous upon admission.~~
- ~~☐ Enoxaparin (Lovenox) 40 mg subcutaneous upon admission.~~
  ~~Heparin 5,000 units subcutaneous upon admission.~~
- ~~☐ Other:~~ _____

PREP:

- ☑ Pre-operative Chlorhexidine bath
- ☐ Have patient void prior to surgery

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

Tri-City Medical Center
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INPATIENT PRE-SURGICAL AM ORDERS

- ☐ Foley Catheter in O.R.
- ☐ Other:_____

CONSULTS:

- ☐ Physical Therapy Consult
- ☐ Social Service Consult
- ☐ Other: _____

MISCELLANEOUS:

- ☐ CPAP Settings_____
- ☐ Incentive Spirometer Instructions
- ☐ Ostomy Nurse to mark stoma site
- ☐ Other:_____

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

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INPATIENT PRE-SURGICAL AM ORDERS

DIAGNOSIS: _____

KNOWN ALLERGIES: _____ ☐ NKDA

ADMIT TO: ☑ Pre-Op Hold

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

DIET: ☐ NPO after midnight or ☐ NPO after_____AM or_____PM

SURGICAL PROCEDURE/CONSENT FORM TO READ: _____

_____

LABS/DIAGNOSTICS:

- ☐ CBC ☐ PT/PTT ☐ Creatinine ☐ C7 ☐ C12
- ☐ Glucose ☐ Capillary blood glucose
- ☐ Urinalysis: ☐ Routine ☐ Microscopic ☐ C&S if greater than 5 WBC/HPF
- ☐ HCG~~:~~, ~~☐ Blood ☐ Urine~~
- ☐ **HCG, Serum * Note: Indicated for women of childbearing age (women greater than 55 years) or no documented instance of bilateral tubal ligation, bilateral oophorectomy, hysterectomy**
- ☐ ☐ K^+ if patient on dialysis AM of surgery
- ☐ Other Labs_____
- ☐ LABS to be done at:_____**Send results to TCMC or FAX to (760) 940-4059**
- ~~☐~~ ECG. Pre-Op ~~for males over 40 years of age~~**if > 60 years of age, cardiovascular disease, chronic obstructive pulmonary disease, diabetes or renal disease;** ~~or relevant history~~
- ☐ **May use recent** ECG **(done within the last six months).** ~~Pre-Op for females over 50 years of age or relevant history~~
- ☐ Chest X-Ray Pre-Op ~~over 60 years of age or relevant history~~ **if evidence of acute cardiopulmonary disease by exam, or > 70 with chronic cardiopulmonary condition and no CXR within past six months.**
- ☐ X-Rays to be pulled for case:_____
  Where X-Rays done:_____
- ☐ Type & Rh ☐ Type & Screen ☐ Sign Blood Transfusion/Refusal Consent
- ☐ Provide a copy of *Patient's Guide to Blood Transfusions*
- ☐ Type and Cross for:_____units ☐ Random Units ☐ Donor Specific ☐ Autologous, if available
  Has patient received transfusion within last 3 months ☐ Yes ☐ No
  Has patient been pregnant within the last 3 months ☐ Yes ☐ No

IV FLUIDS:

- ☐ ~~Buffered~~ Lidocaine 1% 0.2 mL intradermal for IV insertion pre-op.
  ~~***Note: For Buffered Lidocaine preparation: use 20 mL bottle of 1% Lidocaine, remove 2 mL of Lidocaine and add 2 mL of sodium bicarbonate 8.4%**~~
- ☐ Start IV with 16 - 20 gauge catheter with Lactated Ringers 1000 mL at 20 mL/hr rate
- ☐ Other:_____

MEDICATIONS:

- ☐ Fleets enema PR X_____ ☐ H.S. ☐ In AM of surgery (at home)
- ☐ Cefazolin[e1] ~~1~~ **2 grams** (IVPB) attach to chart, to be administered ~~30 minutes~~ prior to incision

Nurse's – Initials

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- ☐ **Cefazolin 3 grams (for patients > 120kg) (IVPB) to be administered prior to incision**
- ☐ Gentamicin ___mg (IVPB) attach to chart, to be administered ~~30 minutes~~ prior to incision
- ☐ Cefotetan 2 grams (or Cefoxitin[e2] 2 grams if cefotetan is unavailable) (IVPB) attach to chart, to be administered ~~30 minutes~~ prior to incision
- ☐ **Cipro 400mg (IVPB) attached to chart to be administered prior to incision**
- ☐ **Genatmicin_____ mg (IVPB) attach to chart, to be administered prior to incision**
- ☐ **Levaquin _____mg (IVPB) attach to chart, to be administered prior to incision**
- ☐ **Vancomycin, 1 gram [e3](IVPB) attach to chart, to be administed [e4]prior to incision**

PREP:

- ☐ **Have patient void prior to surgery**
- ☐ **Foley catheter in O.R.**

MISCELLANEOUS:

- ☐ **Evaluate Postoperative Home Care needs**

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

OUTPATIENT POST-OPERATIVE ORDERS

Admit to: ☐ **PACU** ☐ **SPRA**

- ☐ **Vital Signs: Phase I: Q5 min. X 4, Q15 min. until discharge criteria is met. Phase II: Admit and Discharge.**
- ☐ **Diet as tolerated**
- ☐ **Discharge IV when stable**
- ☐ **Give Physician Initiated post-op instruction sheet for:**
  ☐ **GENERAL** ☐ **GYN** ☐ **ENT** ☐ **ORTHO** ☐ **Other:_____**
- ☐ **Resume home medications on discharge.**
- ☐ **Other:_____**
- ☐ **Discharge patient when discharge criteria met.**

☐ Read Back all T.O./V.O.orders

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

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DVT PROPHYLAXIS:

☐ Sequential Compression Device to be applied in O.R.
☐ Thigh high graduated compression stockings
☐ Knee high graduated compression stockings

PREP:

☐ Have patient void prior to surgery
☐ Foley catheter in O.R.

MISCELLANEOUS:

☐ Evaluate Postoperative Home Care needs

Nurse's Signature	Physician's Signature

OUTPATIENT POST-OPERATIVE ORDERS

Admit to: ☐ PACU

☐ Vital Signs: Phase I: Q5 min. X 4, Q15 min. until discharge criteria is met. Phase II: Admit and Discharge.
☐ Diet as tolerated
☐ Discharge IV when stable
☐ Give Physician Initiated post-op instruction sheet for:
☐ GENERAL ☐ GYN ☐
☐ Resume home medications on discharge.
☐ Other: _____
☐ Discharge patient when discharge criteria met.

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

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DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
July 7, 2015

Members Present: Larry W. Schallock, Chairperson; Director Ramona Finnila; Director RoseMarie V. Reno; Blake Kern, Community Member; Eric Burch, Community Member; Al Memmolo, Community Member; Dr. Paul Slowik, Community Member; Dr. Marcus Contardo, Physician Member; Dr. Henry Showah, Physician Member

Non-Voting Members: Greg Moser, General Counsel; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO

Others Present: Teri Donnellan, Executive Assistant; Sherry Miller, Manager, Medical Staff Office; Esther Beverly, VP/Human Resources; Gwen Sanders, Community Member

Absent: Tim Moran, CEO

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order/Introduction	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Schallock, Committee Chairman. Chairman Schallock introduced and welcomed Chief Compliance Officer Cheryle Bernard-Shaw who joined Tri-City on July 1st. Ms. Bernard-Shaw provided a brief summary of her background stating she comes to Tri-City from Sutter Health with a legal background and Masters in Health Administration.		
2. Approval of Agenda	**It was moved by Director Reno to approve today's agenda as presented. Director Finnila seconded the motion. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Schallock read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Finnila and seconded by Dr. Paul Slowik to ratify the minutes of the June 2, 2015 Governance & Legislative Committee. The minutes were approved unanimously.**	Minutes ratified.	Ms. Donnellan
6. Old Business –			

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

a. Review and discussion of amendments to Board Policy 14-043 External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms	In follow-up to discussion at last month's meeting, Mr. Moser discussed the revisions to Board Policy 14-043. He explained the policy was amended to include external and affiliated organizations as well as meetings of the Medical Staff. Minor grammatical revisions were suggested and accepted by the committee. **It was moved by Director Finnila to recommend approval of Board Policy 14-043 External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms as presented with revisions as described. Dr. Showah seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-043 External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
b. Review and discussion o f amendments to Board Policy 14-031 Members on Board Committees, Conflict of Interest	Mr. Moser explained the amendments to Board Policy 14-031 were designed to accomplish the following: 1. Allow a community member to continue in office past his/her term expiration until a successor is appointed; and 2. Provide clarification that Community Healthcare & Alliance Committee appointees need only be employed by the local agency or business within the boundaries of the District and not necessarily reside in the District. **It was moved by Director Reno to recommend approval of amended Board Policy 14-031 Members on Board Committees, Conflict of Interest. Dr. Showah seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve amended Board Policy 14-031 Members on Board Committees, Conflict of Interest; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
c. Review and discussion of amendments to Board Policy 14-029 Protest or Demonstration on District Property Outside of Public Meetings	In follow-up to discussions at the June meeting, Mr. Moser explained Board Policy 14-029 has been updated to apply to all Tri-City facilities and identify other policies that supplement Policy 14-029. Mr. Moser also explained that Mr. Moran has suggested		

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	additional language after the words ***"where patients may be present"*** to include ***"or could be disruptive to normal hospital operations"***. Director Reno questioned whether the distance of "fifty feet" should be revised to a distance of 100 feet. Mr. Moser explained fifty feet is based on what is termed as "reasonable distance" and has been somewhat court tested. **It was moved by Director Finnila to recommend approval of Board Policy 14-029 – Protest or Demonstration on District Properties Outside of Public Meetings as presented to include the additional language referenced by Mr. Moran. Dr. Slowik seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve amendments to Board Policy 14-029 Protest or Demonstration on District Property Outside of Public Meetings; item to appear on next Board agenda and included in Board Agenda packet	Ms. Donnellan
d. Review and discussion of new Board Policy 15-027 – Solicitation and Distribution of Literature on District Properties	In follow-up to discussion at the June meeting, Mr. Moser presented new Board Policy 15-027 – Solicitation and Distribution of Literature on District Properties. He explained the policy is a culmination of Administrative Policy & Procedure 8610-210 which has not been enforced. Mr. Moser stated the policy is designed to apply to everyone within the facility and identifies working areas of the hospital and non-working areas where solicitation is permitted. He clarified that Board Policy 15-027 would replace Administrative Policy 8610-210. Ms. Esther Beverly, VP of Human Resources stated enforcement of the policy as written will be a change from what has been practiced. Mr. Moser suggested an inventory of users be brought forward to determine what should be incorporated and possibly exempt from the policy. Mr. Kapua Coley reiterated that there has not been enforcement of the policy in the past and it will be a culture shift as to how it is enforced. It was also suggested the title be revised to include not only literature but durable goods.		

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	The committee directed Mr. Moser to bring the policy back to the committee in August and identify a list of users and rename the policy to capture what we are trying to regulate.	General Counsel to draft revisions to Board Policy 15-027 and bring back to the committee at their August meeting.	General Counsel
7. New Business a. Medical Staff Rules & Regulations 1. Division of Internal Medicine	Ms. Sherry Miller, Manager of the Medical Staff reported the Medical Staff has 28 sets of Rules & Regulations that will be coming forward for review. She stated the goal will be to combine some of the smaller departments. Ms. Miller stated there are no recommended changes to the Division of Internal Medicine Rules & Regulations. Mrs. Blake Kern recommended minor grammatical changes which were accepted by the committee. **It was moved by Director Finnila to recommend approval of the Division of Internal Medicine Rules and Regulations as presented and amended. Director Reno seconded the motion. The motion passed unanimously.**	. Recommendation to be sent to the Board of Directors to approve Division of Internal Medicine Rules & Regulations; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
2. Department of Anesthesiology	Ms. Sherry Miller reviewed the redlined changes to the Department of Anesthesiology Rules & Regulations. In addition to punctuation changes, it was suggested for clarification the word ***"cases"*** be added to the section on Proctoring. In addition the word ***"compromised"*** should be revised to read ***"comprised"*** in Section IX. first sentence. Ms. Miller clarified Pediatric Anesthesia was deleted from the Cognitive Privileges section due to the fact that we no longer have a Pediatric program at Tri-City Medical Center. **It was moved by Director Finnila to recommend approval of the Department of Anesthesiology Rules**	Recommendation to be sent to the Board of Directors to approve	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	& Regulations as presented and amended. Mr. Eric Burch seconded the motion. The motion passed unanimously.	Department of Anesthesiology Rules & Regulations; item to appear on next Board agenda and included in Board Agenda packet.	
3. Department of General & Vascular Surgery	Ms. Sherry Miller reviewed the redlined changes to the Department of General & Vascular Surgery Rules & Regulations. Ms. Miller noted the redlined should be removed from page 11, Initial Appointment Section ***"or current certificate of training"***. It was suggested punctuation be reviewed for accuracy. **It was moved by Director Finnila to recommend approval to the Board of Directors the Department of General & Vascular Surgery Rules & Regulations as presented and amended. Mrs. Blake Kern seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Department of General & Vascular Surgery Rules & Regulations; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
b. Review and discussion of TCHD Bylaws, Article V, Section 1, Committees	Chairman Schallock stated a recommendation has been made to prohibit the use of ballots in any committee deliberations. Mr. Moser stated under Roberts Rules of Order rank voting can occur and although the District uses Roberts Rules of Order as a guideline, an effort has been made to comply with the Brown Act which forbids the use of secret ballots. Mr. Moser further explained the proposed revision to Article V. Section 1.of the Bylaws prohibits the use of written ballots, whether secret or not secret for any purpose in its deliberations. Director Reno suggested Board members be reminded to read and understand the Bylaws and Board policies to avoid any confusion. Mr. Moser confirmed education related to Bylaws and Policies is provided to newly elected Board members as well as re-elected Board members during Board orientation. **It was moved by Director Reno to recommend approval of Article V. Section 1 of the Bylaws as presented. Mr. Eric Burch seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve TCHD Bylaws, Article V. Section 1 as presented; item to appear on next	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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		Board agenda and included in Board Agenda packet.	
c. Review and discussion of Resolution 774 – A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents related to Tri-City Medical Center and other Affiliated Entities	Mr. Moser reported Resolution 774 was developed to provide clarification to vendors and outside entities and confirm the name used by the District in contracts and other documents related to Tri-City Medical Center. **It was moved by Director Finnila to recommend approval of Resolution 774 – A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents related to Tri-City Medical Center and other Affiliated Entities. Mr. Eric Burch seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Resolution 774 – A Resolution of the Board of Directors of Tri-City Healthcare District Confirming the Name Used by the District in Contracts and Other Documents related to Tri-City Medical Center and other Affiliated Entities; item to appear on next Board agenda and included in Board Agenda packet.	Ms. Donnellan
d. Review and discussion of reporting guidelines for Policies and Procedures including Administrative, Compliance, IT and Unit Specific	Chairman Schallock reported Administrative Policy 8610-240 was brought forward today to explain the approval process for all policies in the organization. Director Reno expressed concern that not enough discussion was delegated to Emergency/Disaster policies at the July Board meeting and the Board should have more responsibility for these policies. It was explained that the Emergency/Disaster policies were reviewed extensively at a committee of the Board, the Professional Affairs Committee and the committee recommended approval by the Board. Chairman Schallock suggested Board members pull policies from the Board's Consent Agenda if they do not sit on that particular committee and feel the need for further discussion. Mr. Moser questioned if the Medical Staff Rules & Regulations should be reviewed by the Governance Committee as indicated by the policy or by the Professional Affairs Committee. Chairman Schallock stated it is his preference that the Governance		

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	Committee continues to review Medical Staff Rules & Regulations, along with the Medical Staff Bylaws. **It was moved by Director Finnila to recommend the approval Administrative Policy 8610-240 as presented. Dr. Paul Slowik seconded the motion. The motion passed unanimously.**	Administrative Policy 8610-420 will be sent forward to the AP&P Committee for approval through the appropriate channels.	Ms. Donnellan
e. Review and discussion of proposed policy change related to the number of "major" topics for discussion at any one Board meeting.	Director Reno requested that the committee revisit the practice of scheduling additional major topics on the Regular monthly Board Agenda. She suggested that candidate interviews and other major topics be discussed at a separate Special Meeting. Mr. Moser explained that Board Policy 14-010 Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson limits the duration of open session to three and one-half (3-1/2) hours but does not have a corresponding restriction on closed session. It was suggested a time limit be set for closed session of four hours. The committee directed Mr. Moser to draft a revision to Board Policy 14-010 to include a four- hour time limit restriction for closed session and bring back to the committee for review.	General Counsel to draft revision to Board Policy 14-010 to include a four-hour time limit restriction for closed session. Revised policy to be placed on the committee's August agenda.	General Counsel
7. Discussion regarding Current Legislation	Chairman Schallock reported the Governor signed the 2015-16 state budget on June 24, 2015 and the Legislature continues to work on the Medi-Cal reimbursement issue. Discussion was held regarding a potential vote in November related to the definition of an Inpatient vs. Observation status. Dr. Showah stated this is most likely tied to reimbursement. Mr. Kapua Conley noted the Two Midnight Rule is expected to be revised which may work in the hospital's favor.	Information only.	
8. Review of FY2016 Committee Work Plan	The FY2016 Committee Work Plan was included in today's meeting packet for reference.	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

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9. Committee Communications	Director Reno requested follow-up on the delivery of Trustee Magazine subscription. She noted the CHA Daily Briefings provide a great deal of useful information and she appreciates the publication. Dr. Contardo reported next month the committee will review the proposed Medical Staff Bylaw revisions with the goal of forwarding the document for Board approval in August. Mr. Kapua Conley reported the Joint Commission is scheduled for their triennial visit in early fall. He stated a consultant will be onsite in two weeks to conduct an evaluation of our progress. Mr. Conley stated our paperwork is in order and we believe we will be more than ready for the Joint Commission's visit. In follow-up to earlier discussion on the hospital's Disaster Plan, Dr. Showah reported Dr. Chad Bernhardt a Board Certified Emergency Medicine physician is on the Disaster Team, along with Dr. Ryan Smith, who is also Board Certified in Emergency Medicine. He noted Dr. Smith is currently working on protocols related to fire and smoke inhalation. Director Finnila reiterated the Professional Affairs Committee reviewed in detail the Emergency Disaster Plan that was brought forward to the Board for approval at the June meeting.		
10. Community Openings – None	There are currently no openings on the committee.		
11.Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, August 4th, at 12:30 p.m.		
12. Adjournment	Chairman Schallock adjourned the meeting at 1:46 p.m.		

I. MEMBERSHIP

The Division of Internal Medicine consists of physicians who practice within the specialties of:

- Internal Medicine
- Endocrinology
- Infectious Disease
- Nephrology
- Rheumatology
- Physiatry (Physical Medicine and Rehabilitation)

Division members practicing Internal Medicine shall be board certified in internal medicine by the American Board of Internal Medicine or American Osteopathic Board of Internal Medicine, or have successfully completed an ACGME or AOA-accredited residency in Internal Medicine and are able to demonstrate comparable ability, training and experience.

Division members practicing Endocrinology, Infectious Disease, Nephrology or Rheumatology shall be board certified in internal medicine and the applicable sub-specialty by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine, or successfully completed an ACGME or AOA-accredited residency in internal medicine and applicable sub-specialty residency/fellowship and are able to demonstrate comparable ability, training and experience.

Division members practicing Physical Medicine and Rehabilitation are board certified by the American Board of Physical Medicine and Rehabilitation, or have completed an ACGME/AOA-accredited physical medicine and rehabilitation residency training program and are able to demonstrate comparable ability, training and experience.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Internal Medicine shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Division review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;

H. Recommend or Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of Internal Medicine shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a one year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Medicine and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Medicine or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

D. All members of the Division of Internal Medicine are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of internal medicine although not necessarily at the level of sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:

1. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
2. Unexpected complications arise which are outside this level of competence;
3. Specialized treatment or procedures are contemplated with which they are not familiar.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit patients Consultation History and physical examination	1. Board certified in Internal Medicine or applicable sub-specialty by the American Board of Internal Medicine; or 2. Successful completion of an ACGME or AOA-accredited residency in internal medicine.	Six (6) in-hospital cases (~~Admit patients must include~~ At least ~~five (5) conventional care and one (1)~~ three (3) must be telemetry or ICU admissions).	N/A
Surgical Assistant	See Policy 8710-536	See Policy 8710-536	See Policy 8710-536
Moderate sedation	See Policy 8710-517	See Policy 8710-517	See Policy 8710-517
INTERNAL MEDICINE PROCEDURES			
• Arthrocentesis • Central venous catheter insertion* • Cyst Aspiration • Excision of subcutaneous lesions not requiring skin grafts • Flexible sigmoidoscopy • Incision and Drainage • Lumbar puncture* • Paracentesis* • Percutaneous arterial catheter	1. Board certified in Internal Medicine by the American Board of Internal Medicine; or 2. Successful completion of an ACGME or AOA-accredited residency in internal medicine and documentation of ten (10) cases within 24 months prior to application	Two (2) cases from this category	Ten (10) cases from this category. If a privilege is annotated with an asteric (*), one (1) case is required, which counts in the total category volume requirements.

insertion*			
• Read EKGs/supervise treadmill EKGs			
• Removal of toenail			
• Skin biopsy			
• Suturing			
• Thoracentesis*			
• Treatment of patients in an intensive care environment			
• Venous cutdown			
ENDOCRINOLOGY PROCEDURES			
• Admit, evaluate, diagnose, consult, perform history and physical examination, and provide treatment to patients presenting with illnesses, injuries, or disorders of the endocrine or metabolic systems, including diabetes.	1. Board certified in Endocrinology, Diabetes, and Metabolism by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine; or 2. Successful completion of an ACGME or AOA-accredited residency in internal medicine or applicable sub-specialty residency/ fellowship and documentation of the management of endocrinology, diabetes, and metabolism problems for at least twenty (20) patients with in the 24 months prior to application.	Six (6) cases	Twenty (20) cases
• Fine needle thyroid aspiration	Five (5) cases within 24 months prior to application	One (1) case	One (1) case
NEPHROLOGY PROCEDURES			
• Continuous arteriovenous hemofiltration	1. Board certified in the subspecialty of Nephrology by the	Two (2) cases from this category	Ten (10) cases from this

• Hemodialysis • Peritoneal dialysis • Plasmapheresis • Renal biopsy	2. American Board of Internal Medicine; or Successful completion of an ACGME or AOA-accredited internal medicine residency and either a residency or fellowship in nephrology, and documentation of ten (10) cases within 24 months prior to application.		category
PAIN MANAGEMENT ~~- (Per Policy 8710-541):~~			
~~**Pain Management Core Privileges**~~ • ~~Epidural procedures~~ • ~~Joint injections~~ • ~~Sympathetic blocks~~ • ~~Chemo-denervation~~	~~See Policy 8710-541~~	~~See Policy 8710-541~~	~~See Policy 8710-541~~
~~**Pain Management Special Procedures**~~ • ~~Discogram~~ • ~~Radiofrequency Thermocoagulation lesion ablation (RFTC)~~ • ~~Intradiscal electrothermal annuloplasty~~ • ~~Implantables~~	~~See Policy 8710-541~~	~~See Policy 8710-541~~	~~See Policy 8710-541~~
Pain management privileges	Per Medical Staff policy 8710-541	Per Medical Staff policy 8710-541	Per Medical Staff policy 8710-541

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is

established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Division will act as proctors. An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued of deficiencies noted.

C. **THE MONITOR MUST BE PRESENT FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PHYSICIAN'S COMPETENCE.**

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).

E. The member shall have free choice of suitable consultants and assistants.

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

G. A form shall be completed by the proctor, and should include comments on pre-procedure workup, diagnosis, pre-procedure preparation, technique, judgment, post-procedure care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.

H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

IX. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

A. The Department of Family Medicine (FM) Quality Review Committee and the Division of Internal Medicine (IM) Quality Review Committee shall be combined into the Internal Medicine/Family Medicine (IM/FM) Quality Review Committee (QRC). The combined IM/FM QRC shall be comprised of no less than two (2) Family Medicine Department members and two (2) Internal Medicine Division members. The Committee chairman may alternate between the Department of Family Medicine and the Division of Internal Medicine as determined by the QRC and each department/division shall have a representative on the Medical Staff QA/PI Committee The Department Chairperson shall appoint the remaining members for a two (2)-year term. Committee members shall be eligible to succeed themselves. The QRC shall meet at least four (4) times per year.

B. **General Function**

1. The IM/FM QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by department members to patients in the hospital.

C. **Specific Functions:**

1. The QRC is established to:
   - i Identify important elements of patient care;
   - ii Establish performance monitoring indicators and standards related to these elements of care;
   - iii Select and approve performance monitoring indicators;
   - iv Integrate relevant information for these indicators and review quarterly as related to these performance monitoring indicators;
   - v Review and evaluate physician practice when specific thresholds are triggered;
   - vi Identify areas of concern and opportunities for improved care and safety, and educate Department members based on these reviews;

vii Highlight significant clinical issues and present the specific information regarding qualify of care to the appropriate Department member, in accordance with Medical Staff Bylaws;

viii Request, if needed, Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;

ix Monitor and review the effectiveness of intervention and document change.

D. **Other Functions:**

1. Assist in the reappointment process through retrospective review of charts;
2. Review any Internal Medicine-related issues received from other departments;
3. Assist in the collection, organization, review, and presentation of data related to patient care, safety, and department clinical pathways;
4. Review cases involving death(s) in the hospital as applicable by approved departmental indicators.

E. **Reports**

1. Minutes shall be submitted to the Medical Staff QA/PI Committee and the Medical Executive Committee. The QRC shall provide minutes, and as needed, verbal or written communication regarding any general educational information gleaned through chart review or the Performance Improvement process to Department members and to the QA/PI Committee.

X. EMERGENCY CALL

Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.

While serving on the Emergency Department Call Roster, each member shall respond to requests from the Emergency Department by examining and treating patients in the Emergency Department, unless the member and the Emergency Department physician determines that such care may be provided in the member's office. Any member who elects to provide care in his/her office must do so without regard to the patient's ability to pay, and must provide a minimum level of care sufficient to respond to the patient's immediate needs.

When it is discovered that a staff member has previously treated a patient, that member will be given the opportunity to provide further care. The member will then determine whether to provide further care to an Emergency Department patient based upon the circumstances of the case. If a member declines, the on-call physician for unassigned patients will provide any necessary emergency special care.

Provisional and Courtesy staff members may be assigned to the Emergency Department Call Roster by the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Internal Medicine: 06/04/2015
Department of Medicine: 06/12/2015
Medical Executive Committee: 06/22/2015
Governance Committee: 07/07/2015
Board of Directors:

I. MEMBERSHIP

As part of the Department's goal to ensure that its physicians meet high standards of clinical quality, the Department has determined that Board Certification is an important indicator of quality. Therefore, the Department of Anesthesiology consists of physicians who are at all times and remain Board Certified by the American Board of Anesthesiology (ABA), or are a candidate in the ABA examination system, as determined by the American Board of Anesthesiology. ~~Physicians who make an initial application to join the Department after January 1, 2013, must become Board certified within five (5) years of joining the Department.~~ Department members with time-limited certificates must participate in the ABA's Maintenance of Certification in Anesthesiology (MOCA) program in order to maintain their certification. For those members who have non-time limited certificates, the Department recommends participation in the MOCA program.

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Anesthesiology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practices;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the QA/PI/PS Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DEPARTMENT MEETINGS

The Department of Anesthesiology shall meet quarterly or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/PS Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Department members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

The Department shall have a Chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical area of Anesthesiology. The Department Chair shall be elected every two (2) years by the Active members of the Department who are eligible to vote. Vacancies for any reason shall be filled for the unexpired term through a special election. The Chair shall be elected by a simple majority of the members of the Department. The Department Chair shall serve a two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.
The Vice Chair will be the prior Chairman and a Quality Review Committee Chairman will be appointed.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Department;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
C. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
D. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege card;
E. Recommend clinical privileges for each member of the Department;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
G. Other duties as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.
C. Requests for privileges in the Department of Anesthesiology shall be evaluated on the basis of the member's education, training, experience, demonstrated current professional competence and judgment, clinical performance, and the documented results of patient care and proctoring.
D. Practitioners shall practice only within the scope of their privileges as defined within the respective Department rules and regulations. Recommendations for privileges are made to the Credentials Committee and Medical Executive Committee.

COGNITIVE PRIVILEGES	Initial	Proctoring	Reappointment every two years
Consultation	N/A	N/A	N/A
Perform history and physical examination	N/A	N/A	N/A

COGNITIVE PRIVILEGES	Initial	Proctoring	Reappointment every two years
Evaluate and treat patients with anesthesia related problems	N/A	N/A	N/A
CORE PROCEDURAL PRIVILEGES	**Initial**	**Proctoring**	**Reappointment every two years**
General Anesthesia	Training	3	20
Regional Anesthesia	Training	2	5
~~Pediatric Anesthesia (children 5 years & under)~~	~~Training~~	~~N/A~~	~~2~~
Invasive Monitoring, including: Arterial line Central line Pulmonary Artery Catheter	Training	N/A	5

Cardiac Anesthesia Criteria - Cardiac anesthesia privileges are considered for applicants who fall under one of the following two categories:

Category 1:

Successful completion of cardiac anesthesia fellowship OR completion of six-months of focused cardiac anesthesia training during third year of residency OR documentation of current activity managing cardiopulmonary bypass cases.

Category 2:

Completion of approved anesthesia residency training program that included three (3) months of cardiac anesthesia with additional proctoring: 1) Five (5) cases will be proctored via direct observation; and 2) Twenty-five (25) prospectively reviewed cases where the plan for anesthesia is discussed with an eligible proctor and the proctor reviews the case retrospectively.

SPECIAL PROCEDURES	Initial	Proctoring	Reappointment every two years
Cardiac anesthesia	See above.	See above.	5
Transesophageal echocardiography (TEE)	1. Cardiac fellowship training, or 2. Documentation of recent training program where TEE was part of training, or 3. Six (6) months Cardiac Anesthesia residency	3	None
Coronary sinus catheter placement	Successful completion of all privileging criteria for Cardiac Anesthesia (Category 1 or 2), and current flouroscopy license.	2	None

SPECIAL PROCEDURES	Initial	Proctoring	Reappointment every two years
	and Transesophageal echocardiography		

OTHER PRIVILEGES	Initial	Proctoring	Reappointment every two years
Admit patients	Training	N/A	N/A
Fluoroscopy	Refer to policy 8710-528 and 8710-528A	N/A	N/A

PAIN MANAGEMENT PROCEDURES	Refer to policy 8710-541

VII. REAPPOINTMENT

Procedural privileges may be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. For Anesthesiology Procedural Privileges, ~~50~~25% of the overall case-specific volume requirement(s) must have been performed at an acute care hospital. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privileges status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active staff members of the Department will act as proctors to monitor quality of performance.

C. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.

D. Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office.

E. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

F. Evaluation of the Medical Staff member by the proctor will emphasize concurrent or retrospective chart review and include direct observation of procedural techniques. The Medical Staff member must notify his proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another anesthesiologist. If the procedure must be done as an emergency without proctoring, the proctor must be informed at the earliest appropriate time following the procedure.

IX. DEPARTMENT QUALITY REVIEW AND MANAGEMENT

The Department of Anesthesiology will have a Quality Review Committee (QRC) ~~compromised~~ comprised of no less than four (4) Department members. The committee chairman is the Department's representative to the Medical ~~Staff QA/PI/PS~~ Quality Peer Review Committee. ~~and the Medical Executive Committee. The Department shall appoint an Active member as a representative to the QA/PI Committee. The Department Chair shall appoint the remaining members for a two (2) year term.~~ Committee members are able to succeed themselves. The QRC will meet ~~at least~~ a minimum of four (4) times per year to review cases in a timely manner.

A. **General Function**

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members.

B. **Specific Functions**

The QRC is established to:

1. Identify important elements of anesthesia care in all areas in which it is provided;
2. Establish performance monitoring indicators and standards that are related to these elements of care;
3. Select and approve their performance monitoring indicators;
4. Integrate relevant information, as indicated, and review quarterly;
5. Formulate thresholds for evaluation related to performance monitoring indicators.
6. Review and evaluate physician practice when specific thresholds are triggered;
7. Identify areas of concern, opportunities to improve care and safety, and educate Department members based on these reviews;
8. Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate Department member, in accordance with Medical Staff Bylaws;
9. Request Focused Professional Practice Evaluation when/if questions arise regarding a physician's practice;
10. Monitor and review the effectiveness of any intervention and document any change.

C. **Other Functions**

1. Assist in the reappointment process, through retrospective review of charts;
2. Review any issues related to anesthesia that are forwarded for review by other departments;
3. Assist in the collection, organization, review, and presentation of data related to anesthesia care and safety;
4. Review the cases involving an anesthesia related death.

D. **Reports**

Minutes are submitted to the Medical Staff QA/PI/PS Committee and the MEC.

X. EMERGENCY WEEKEND AND NIGHT CALL

Individuals administering twelve (12) or more anesthesia cases in a year must maintain their active medical staff membership. Active medical staff members shall participate in anesthesia emergency, weekend, and night call as determined by the Department.

Approvals:

Department of Anesthesiology – ~~11/13/12~~ 05/21/2015
Medical Executive Committee – ~~11/26/12~~06/22/2015
Governance Committee - 07/07/2015
Board of Directors – ~~12/13/12~~

Med Staff R&R – Anesthesiology-Revised 5/07, 6/08, 4/09; 10/10; 1/11; 12/12; 7/15

I. **MEMBERSHIP**

The Division of General and Vascular Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Surgery, or able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of General and Vascular Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;
B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;
C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Division clinical practice;
D. Review and evaluate Division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;
E. Submit written minutes to the QA/PI Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;
F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;
G. Take appropriate action when important problems in patient care, patient safety, and clinical performance or opportunities to improve patient care are identified;
H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);
I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DIVISION MEETINGS**

The Division of General and Vascular Surgery shall meet at the discretion of the Chief, but at least quarterly. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. **DIVISION OFFICERS**

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active Staff members of the Division who are eligible to vote. If there is a vacancy for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of members of the Division.

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in that Division. Division officers shall be eligible to succeed themselves.

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Accountability for all professional and administrative activities of the Division;
B. Ongoing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Ensuring practitioners practice only within the scope of the privileges defined within their delineated privilege form;
D. Recommendations to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommendations of clinical privileges for each member of the Division;
F. Ensuring that the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended by the Department of Surgery or the Medical Executive Committee.

VI. **PRIVILEGES**

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office;
B. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated;
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified;
D. **Physician Assistants** – In accordance with Department of Surgery rules and regulations;
E. **Registered Nurse First Assist (RNFA)** – In accordance with Department of Surgery rules and regulations;
F. **Forensic Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the Forensic Outpatient Clinic.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Admit Patients Consultation, including via telemedicine (F) Perform Medical History & Physical Examination, including via telemedicine (F)	Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience.	Completion of General Surgery proctoring satisfies proctoring for these privileges	N/A
BASIC GENERAL SURGERY PRIVILEGES			
• Anal canal biopsy (F) • Anoscopy (F) • Arterial catheterization for monitoring	• Board certification, or in the first 36 months of Board eligibility and	Ten (10) cases	Sixty (60) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular) • Biopsy / excision skin & soft tissue lesions (F) • Central venous catheter placement • Chemical destruction of anal warts (F) • Cricothyroidotomy • Debridement of wound, soft tissue infection • Excision of neuroma, neurofibroma, neurilemoma • Excision of skin, soft tissue neoplasm • I&D abscess (F) • Intraoperative Endoscopy, concomitant to surgical procedure • Minor laceration repair • Neurorrhaphy - Suture of Nerve • Paracentesis • Parathyroidectomy • Radical neck dissection, modified • Right heart catheterization for monitoring • Rigid proctoscopy (F) • Rubber band ligation of internal hemorrhoids (F) • Sentinel lymph node biopsy • Sigmoidoscopy, includes rigid or flexible • Thoracentesis • Thyroidectomy • Tracheostomy • Tube thoracostomy **Abdomen and Perineum Surgery:** • Abdominal perineal resection • Abdominal wall repair, inguinal or femoral hernia, laparoscopic • Adrenalectomy, open • Anal sphincterotomy • Anti-reflux procedures, open	actively pursuing certification by the American Board of Surgery, or demonstrated comparable ability, training or experience. • One-hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA-accredited residency or clinical fellowship within the previous (24) months.		

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Appendectomy, open or laparoscopic • Cholecystectomy, open or laparoscopic • Choledochoenteric anastamosis • Colostomy, closure • Colostomy, creation, open or laparoscopic • Common bile duct exploration, transcystic, open or laparoscopic • Diagnostic laparoscopy with or without biopsy • Drainage of anorectal abscess • Drainage of intra-abdominal abscess • Drainage of pseudocyst • Enterolysis • Esophageal diverticulectomy, open • Esophagogastrectomy • Exploratory laparotomy • Fasciotomy • Gastrectomy, partial or total • Hemorrhoidectomy • Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral, open or laparoscopic • Hernia, repair of diaphragmatic or hiatal, open • Ileostomy creation or closure • Intestine resection (small or larger intestine), open or laparoscopic • Liver biopsy, open or laparoscopic • Lymphadenectomy • Lysis of adhesions, open or laparoscopic • Pilonidal cystectomy • Repair of anorectal fistula • Repair of rectal prolapse • Splenectomy, open • Ulcer surgery, (Omental patch, V&A, V&O, V&GJ, HSV, etc), open • Vagus transection, for peptic ulcer disease			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Breast Surgery: • Axillary dissection • Biopsy, incisional or excisional • Breast abscess, drainage of • Intraoperative needle localization • Intraoperative ultrasound • Mastectomy, partial • Mastectomy, total • Mastopexy **Urogenital Surgery:** • Bladder repair, incidental • Hydrocelectomy, incidental • Hysterectomy, incidental • Nephrectomy, incidental • Orchiectomy, incidental • Partial cystectomy, incidental • Salpingo-oophorectomy, incidental or in an acute abdominal emergency • Ureteral repair, incidental • Skin grafting			
BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES			
• Amputation, digital • Amputation, foot • Amputation, knee, above • Amputation, knee, below • Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency) • Operations for venous ulceration/split thickness skin grafting (STSG) • Sympathectomy - (Including vascular ischemia) • Vein ligation or stripping of varicose veins/phlebectomy • Portal Decompression: • Mesocaval shunt • Portocaval shunt • Splenorenal shunt	Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months.	One (1) case	Five (5) cases
ADVANCED GENERAL SURGERY PRIVILEGES:			
Advanced Breast Surgery: Oncoplastic repair	• Basic General Surgery privileges which effectively covers the need for board certification. • For Oncoplastic Repair	Three (3) cases	Ten (10) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months.		
Advanced Laparoscopic:: • Adrenalectomy , laparoscopic • Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet), laparoscopic • Cholecystenteric anastomosis, laparoscopic • Choledochoenteric anastomosis, laparoscopic • Colostomy closure, laparoscopic • Esophageal procedures, laparoscopic • Gastric resection , laparoscopic • Hepatic resection , laparoscopic • Hernia repair, diaphragmatic or hiatal, laparoscopic • Pancreatic procedures, laparoscopicSplenectomy, laparoscopic • Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc), laparoscopic	• Basic General Surgery privileges which effectively covers the need for board certification. • Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months.	Three (3) cases from this category	Twenty-four (24) cases from this category
Advanced Abdominal:			
• Esophagectomy, including thoracoabdominal approach • Hepatic lobectomy, open • Hepaticoenterostomy • Pancreatic procedures, open or laparoscopic	• Basic General Surgery privileges which effectively covers the need for board certification. • Two (2) advanced abdominal procedures during the previous twenty-four (24) months.	One (1) case from this category	Two (2) cases from this category

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Advanced Head & Neck Surgery: • Parotid gland • Salivary glands & ducts • Thymectomy	• Basic General Surgery privileges which effectively covers the need for board certification. • Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months.	Two (2) cases from this category	Ten (10) cases from this category
ADVANCED PERIPHERAL VASCULAR SURGERY:			
• Aortic, aorto-iliac, aorto-femoral bypass • Axillary-femoral bypass • Bypass of upper extremity vessel • Carotid – Subclavian bypass • Celiac/superior mesenteric axis endarterectomy, repair or bypass • Embolectomy or thrombectomy • Endarterectomy, carotid • Endarterectomy or bypass, vertebral • Endarterectomy, repair or bypass, renal artery • Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery • Femoral to femoral bypass • Femoral to infrageniculate bypass • Femoral to popliteal bypass • Repair of aortic branches • Repair of iliac, femoral, popliteal, or mesenteric aneurysm • Repair of infra or suprarenal aortic aneurysm • Repair of upper extremity vessel • Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures* • Upper and lower extremity deep or superficial vein procedures • Upper or lower extremity fistula, autogenous or artificial placement of central venous	• Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification. • Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.) • *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.	• Five (5) cases from this category • * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases	• Twenty (20) vascular cases from this category • *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
catheter placement			
SPECIAL PRIVILEGES:			
Bariatric Surgery: • Roux en Y gastric bypass, open and laparoscopic • Sleeve gastrectomy, open and laparoscopic • Adjustable gastric banding, open and laparoscopic • Revisional metabolic and bariatric surgery, open and laparoscopic • Biliopancreatic diversion, with or without duodenal switch, open and laparoscopic	• Completion of General Surgery residency program. • Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy. • Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases within the previous twenty-four (24) months. • Commitment to participate in TCMC's Bariatric Committee and comply with Medical Staff policy 8710-572. • Documentation to indicate malpractice coverage includes bariatric surgery.	Three (3) cases	• Fifteen (15) cases within the previous twenty-four (24) months • Participatation in TCMC's Bariatric Committee as evidenced by compliance with Medical Staff policy 8710-572.
Colonoscopy	Completion of an ACGME accredited training program in General Surgery or Colon and Rectal surgery within the previous twenty four (24) months. If training was completed greater than twenty four (24) months ago, documentation of a refresher training course in lower endoscopy or documentation of fifty (50) cases within the previous twenty-four (24)	Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than	Ten (10) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	months is required.	twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided, Seven (7) cases if training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of a refresher course was provided.	
Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures	Initial: Completion of an ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.	Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided. Seven (7) cases if	Seven (7) cases within the previous twenty-four (24) months

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
		training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of refresher course was provided.	
Endovenous Ablative Therapy	Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures	Three (3) cases	Five (5) cases
Endovascular Repair of Aortic Aneurysms	Per policy 8710-503	Per policy 8710-503	Per policy 8710-503
Fluoroscopy	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A	Per policies 8710-528 and 8710-528A
KTP Laser	Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used.	Two (2) cases	Two (2) cases
Moderate Sedation	Per policy 8710-517	Per policy 8710-517	Per policy 8710-517
Robotic Surgery – (da Vinci) • Multiple Port • Single Port • Assist in robotic surgery	Per policy 8710-563	Per policy 8710-563	Per policy 8710-563
Transoral Esophagogastric Fundoplication (TIF)	1. Completion of ACGME accredited residency program and possess board certification or board eligibility in Surgery; and 2. Documentation of completion of product-sponsored training course, or have	Three (3) cases	Six (6) cases

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
	performed at least five (5) TIF procedures in the previous twelve (12) months		
Placement of Vagal Nerve Stimulator	1. Basic General Surgery privileges which effectively covers the need for board certification. 2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months **or current certificate of training.** ~~**including Carotid Endarterectomy.**~~	Two (2) cases	Five (5) cases

VII. **REQUIREMENTS FOR REAPPOINTMENT**

A. Active certification by the Division of General Vascular Surgery or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center;

B. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. **PROCTORING OF PRIVILEGES**

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated, until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors;

B. All Active members of the Division will act as proctors. ~~An associate may monitor 50% of the required proctoring~~. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative b) operative, c) surgical technique and/or, d) postoperative care;

C. **THE MONITOR MUST BE PRESENT IN THE OPERATING ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE APPLICANT MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E. H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE;**

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Operating Room Supervisor and/or the Medical Staff Office;

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room Supervisor of the proctor for each case;

I. The proctor's report shall be completed and returned to the Medical Staff Office;

IX. **EMERGENCY DEPARTMENT CALL**:

A. Division members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520;

B. It is the policy of the Emergency Department that when a patient indicates that a staff member has previously treated him or her, that member will be given the opportunity to provide further care;

C. The member of the Division will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care;

D. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. The care provided by an on-call physician will not create an obligation to provide further care;

E. Provisional or Courtesy staff may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair.

APPROVALS:
General & Vascular Surgery Division: ~~3/5/2015~~ 4/9/2015
Surgery Department: ~~3/14/2014~~ 5/8/2015
Medical Executive Committee: ~~3/23/2015~~ 06/22/2015
Governance Committee: 07/07/2015
Board of Directors: ~~3/26/2015~~

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-043

POLICY TITLE: External and Affiliated Organization Usage of Assembly Rooms, Classrooms and Conference Rooms

I. PURPOSE

A. To set forth limitations, requirements and guidelines for public rental/usage of Tri City Medical Center and other District facilities, including assembly rooms, classrooms, and conference rooms by those external and affiliated organizations, groups and persons which support the public purposes of the District.

II. POLICY

A. **Permitted Uses.** Tri City Medical Center assembly rooms, classrooms, and conference rooms shall be available to those public agencies, nonprofit organizations, associations and other groups, which further the health care needs of the public within the boundaries of the Tri-City Healthcare District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District, including meetings of the Medical Staff, and charitable organizations primarily engaged in providing financial or other support to the District.

Although it is a public agency, the use of hospital and other district facilities is dedicated to the provision of health care to the community. By enacting this policy, the District does not intend to create a public forum in its facilities, but only to promote community health and improve health care services delivery within the District.

B. **Compatible Uses**. Public use authorized by this policy shall be solely for meetings and activities which are compatible with the safe, quiet and secure conduct of hospital and health care facility operations, and with the District's status as a public agency of the State of California. For example, several laws prohibit the use of public resources, such as office equipment, staff time, etc., for campaign or personal purposes. (e.g., Gov. Code sections 8314, 85300; Penal Code section 426.) Government Code section 54964 restricts an officer or employee of a local agency from expending or authorizing the expenditure of any local agency funds to support or oppose a ballot measure or a candidate. In addition, the following are prohibited:

1. Tobacco use

2. Alcoholic beverages

3. Political or religious activities

4. Amplified sound which can be heard outside of the room being used

5. Commercial uses

6. Personal use by district employees

7. Animals, other than those needed by disabled persons.

C. **Priority of District Use**. The medical, governance, operational, business and emergency needs of the District shall take precedence over other uses of District property in the scheduling and allocation of space under this policy. Scheduled public uses under this policy are subject to cancellation at the discretion of the District. The District will endeavor to provide as much notice as possible, and will return any deposits made to secure space reservation.

D. **Liability for Damages/Insurance Coverages**. Groups or persons using District facilities under this policy shall agree to be liable for any personal injury, property damage or liabilities arising out of the conduct of the activity or conduct of the participants. The District may charge the amount necessary to repair damages and/or clean the facility, and may deny the responsible group or person further use of District facilities. Groups engaged in activities posing significant risks to the District may be required to provide evidence of liability, property and professional liability insurance. The Chief Nurse Executive may establish such requirements on a case- by-case basis. Examples of activities which may require evidence of insurance include: professional liability insurance for groups offering free medical screening or other medical services; groups exceeding 100 persons. For activities involving more than 100 persons, the District may require evidence of liability and property insurance.

E. **Rules for Use**

1. No signage or placards will be allowed on District premises without the prior written approval of the District. The District provides standard signage to direct participants to the activity location.

2. Halls, entrances, elevators and stairways will not be obstructed or used for any purpose other than ingress/egress under any circumstances.

3. No furniture, freight or equipment shall be brought in without prior notice, and approval by District.

4. No self-provided food services will be permitted without prior notice and approval by District.

5. Unless otherwise specifically approved, hours of usage will be limited to the hours of 7a.m. through to 8:30 p.m. Monday through Friday, excluding District holidays.

F. **Cause for Denial**. The Chief Nurse Executive (CNE) will review all requests by external and affiliated organizations for meeting room space under this policy. Request for space use may be denied for any of the following reasons:

1. The space requested is not available.

2. The applicant is not among those described in paragraph 1.

3. The applicant has not fully complied with this policy.

4. The use proposed will disrupt the provision of medical care or normal hospital or facility operations, or is otherwise incompatible or prohibited under this policy.

5. The applicant has not provided the evidence of insurance required.

6. The applicant has previously failed to comply with this policy.

III. PROCEDURE

A. Applications for usage of assembly rooms, classrooms, and conference rooms are processed via the room scheduler/event coordinator via e-mail or by telephone.

B. The room request form must be completed in full and submitted before applications will be reviewed for compliance with this policy.

C. The room request form will be forwarded to the CNE for review and approval/denial or approval with conditions.

D. The room scheduler/event coordinator will communicate results of request with the applicant.

E. Deposits shall be received at the time the application is submitted.

F. A deposit shall be required for any food services or other special services, facilities, setup or equipment to be provided by the District.

G. The District shall be given 48 hours advance notice of cancellation by a successful applicant, or a cancellation fee will be charged.

H. If the District's needs require cancellation of the planned use by an applicant, advance notice shall be given promptly, and any deposit made shall be returned.

I. If an application is denied, an applicant may appeal to the Chief Executive Officer.

J. The Chief Financial Officer of the District shall establish a schedule of fees and charges, from time to time, based upon the District's reasonably estimated costs for providing services, including but not limited to: Custodial services; room setup; food services; equipment rental. Supplemental charges may also be incurred to cover any unusual staff time or legal expenses which may be incurred in reviewing, processing or accommodating a request. The CNE may condition approval of an application on deposit of estimated supplemental charges, in addition to the payment of scheduled fees and charges. A copy of the basic fee schedule shall be provided with the Facility Request Application and appended to this policy as Exhibit A.

K. The CNE will review the application and determine the deposit required based on this policy, if any. Other than the hourly room rental fee, groups not charging any fee for participation, and those not requiring any special services shall not be charged a fee solely for room use.

Facility Request Application

Name of Meeting and Group: _____

Date(s) requested (or recurring): _____

Start & End Times: _____

Number Attending: _____

Responsible Person & phone number: _____

Purpose of Meeting: _____

Describe relation of meeting/group to district purposes and operations:

_____

_____

Describe facility requested, and any special needs or requests:

_____

_____

Applicant acknowledges that I have read and accepted the terms and conditions of Policy No. ____ regarding the use of District facilities.

_____ Dated: _____
By: [print name]

Deposit required: [to be filled in by District] _____

Deposit received: _____

Reviewed by the Gov/Leg Committee: 4/13/11
Approved by the Board of Directors: 4/28/11
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

EXHIBIT A

FEE SCHEDULE

Organizations/groups will not be charged room rental fees if they are 1) a non-profit with proper proof of such status; and 2) a health-related program intended to further the healthcare needs of the community; and 3) a service fee of $25 per use to cover basic setup, utilities, custodial services, etc., is paid in advance. Any organizations/groups that do not meet all three of these criteria will be charged the below room rental rates in addition to catering, equipment, and any other fees for additional requests.

ROOM TYPE	*HOURLY RATE*
Classroom	*$30*
French Room	*$30*
Assembly Room	*$50*

These fees are for room rental only and are based on total time utilization for the hours reserved. Should the event exceed the hours requested, the user will be billed for the additional time used in hourly increments. Should an event end earlier than reserved, user will not be entitled to a refund of fees paid. Separate charges will be incurred for custom set-up and break-down, catering, equipment, etc. TCHD retains the right to adjust the rental charges when assessing fees for unusual situations or requests.

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-031

POLICY TITLE: Members on Board Committees; Conflicts of Interest

I. RECRUITMENT OF COMMUNITY MEMBERS FOR BOARD COMMITTEES

The following are the procedures for recruitment of community members for vacancies on Board Committees.

A. When a community member vacancy **is scheduled to** occurs on a Board Committee, the District's administration shall:

1. Solicit applications from community members for positions on Board Committees by formally announcing openings at:

   a. Board meetings; and

   b. Board Committee meetings.

2. Solicit applications from community members for positions on Board Committees by advertising openings in a newspaper of general circulation within the boundaries of the Tri-City Healthcare District, not less than once a week for two successive weeks.

3. Solicit applications from community members for positions on Board Committees by posting openings on:

   a. The TCHD website (when availability permits); and

   b. Other public locations where the Tri-City Healthcare District regularly posts agendas for its Board and Board Committee meetings.

B. Solicitations shall include the following:

1. A request that the following information be submitted to the office of the Board Executive Secretary in support of the community members' application for a position on a Board Committee:

   a. A cover letter stating the community member's intention to serve as a Board Committee community member;

   b. A resume or biography delineating the community member's experience relevant to the applicable Board Committee.

c. A declaration of any possible conflicts of interest in a format approved by the Board.

2. A brief description of the scope of topics addressed at the applicable Board Committee, the meeting schedule for the applicable Board Committee, and the term of membership.

3. The following statement:

The Board of the Tri-City Healthcare District desires to ensure that its Board Committee community members are knowledgeable as to the issues that face the District. Therefore, the Tri-City Healthcare District shall only consider applications submitted by persons residing within the boundaries of the Tri-City Healthcare District, or **as to the Community Healthcare Alliance Committee only,** persons employed by a local agency or business within the boundaries of the District who appoint the individual to serve on ~~a Board~~**the Community Healthcare Alliance** Committee on behalf of the local agency or business.

C. The Board Executive Secretary shall forward applications for the position of Board Committee community member to the applicable Board Committee Chair. Applications shall be placed on the next Board Committee Agenda upon the Board Committee Chair's approval.

1. Community member applicants shall be invited to attend the Board Committee meeting at which their membership is considered so that the Board Committee may conduct a brief interview before making its recommendation to the Board.

2. Notwithstanding the above, an application shall not be placed on a Board Committee Agenda until the expiration of 30 days from the first solicitation action taken under Section I above.

D. Upon the recommendation of the applicable Board Committee, the item will be placed on the next Board agenda for final disposition.

E. If the Chair of a Board Committee finds, after completion of the process outlined in Sections A through D above is completed, that the Board Committee still needs one or two subject matter experts on the Board Committee to assist the Board Committee in complying with its charter, the Chair may provisionally appoint, through the date of the next regular Board meeting, not more than two subject matter experts to the Board Committee, subject to Board approval. Subject matter expert(s) for these purposes are individuals that possess special experience based on their experience, training or degree in those matters discussed by the Board Committee, e.g., a financial advisor or certified public accountant for the Audit Committee.

II. TERM OF COMMUNITY MEMBERS ON BOARD COMMITTEES

Unless otherwise expressly provided in the Board Committee's charter, ~~Community~~ members of Board Committees shall serve a term of two years, with an option to renew the appointment for one additional two-year term**, and shall continue to serve until a successor is appointed by the Board**. After the end of his/her term, the community member shall not be eligible to serve on the same Board Committee for at least two years. In addition, it is preferable that a community member shall be a member of no more than one Board Committee at a time. However, it is recognized that circumstances may arise when positions are difficult to fill. Therefore, if a **member's term has expired and no replacement has been appointed within** ~~vacant position remains open for longer than~~ 60 days **of the expiration of the member's term,** and if a community member who sits on a Board Committee wishes to **be reappointed**~~fill the vacant position,~~ the Board Committee ~~with the vacant position~~ may make this recommendation to the Board.

III. EXPIRATION OF TERM DUE TO ABSENCES

The term of any **community** member of a Board Committee shall automatically expire if the member is absent from three (3) consecutive regular meetings of the Committee of which he or she is a member, or from three (3) of any five (5) consecutive meetings of the Committee, except when absences are excused by action of the Committee for matters such as illness or military deployment.

IV. CONFLICTS OF INTEREST

A. Committee members may be designated in the District's Conflict of Interest Code upon a determination that the committee on which they serve is not purely advisory to the Board.

B. Violations of the Conflicts of Interest Code.

In addition to any other remedy provided by law, if the Board of Directors determines that there has been a violation of conflict of interest laws by a Committee Member, the Board may take the appropriate disciplinary and corrective action which may include removal of the Committee Member from the Committee.

C. Inasmuch as Board Committees provide oversight and input into governance matters, employees of the District shall generally be ineligible to serve on any Board Committee as community members. Holding such an office shall be considered to be inconsistent, incompatible, in conflict with or inimical to an employee's duties. Where management employees are appointed to a Board Committee to represent the administration, they shall be counted towards achieving a quorum, but shall not be entitled to vote. However, nothing in this policy shall be construed as prohibiting or discouraging any District employee from speaking at any Board Committee meeting in a personal capacity.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05

Reviewed by the Gov/Leg Committee: 5/10/06
Approved by the Board of Directors: 5/25/06
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07 & 11/07/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by Gov/Leg Committee: 7/13/11
Approved by the Board of Directors: 7/28/11
Reviewed by the Gov/Leg Committee: 3/05/13
Approved by the Board of Directors: 3/28/13
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-029

POLICY TITLE: Protest or Demonstration on District Properties Outside of Public Meetings

The Board of Directors finds that the protection of patients and persons visiting, working and volunteering at the District hospital campus and other District-controlled facilities is of paramount importance. The Board of Directors also recognizes the First Amendment rights of peaceful protesters and demonstrators. To serve these goals, it is the policy of the Board of Directors of the District that any person or persons assembled for a protest or demonstration, or any member of the public engaged in the distribution or display of written or other materials, shall be limited to the public sidewalks that surround the external perimeter of the District hospital campus on Vista Way in Oceanside, as set forth in Exhibit "A" to this Policy, and the public sidewalks immediately adjacent to all other District-controlled facilities, including, but not limited to the Tri-City Wellness Center on El Camino Real in Carlsbad. No person participating in any such expressive conduct or any member of the public engaged in the distribution or display of written or other materials, shall obstruct or interfere with any pedestrian or vehicle entering or exiting the District hospital campus or other District-controlled facility or any entrance to such a facility. In addition, no person on the District hospital campus or at any District controlled facility, including the public sidewalks, shall, either directly or through the use of artificial means of amplification or projection, generate sound that can be heard at a distance of 50 feet or more where patients may be present or which could be disruptive to normal hospital operations. Any expressive conduct shall also comply with any applicable federal state, county and municipal laws, regulations and rules related to the regulation of protest and demonstration on public property.

This policy supplements Board Policy No. 024 (Distribution of Documents at Public Meetings; Board Policy No. 039 (Comprehensive Code of Conduct); and Board Policy No. 43 (External and Affiliated Organization Usage of Assembly Rooms, Classrooms and Conference Rooms) regarding the conduct of persons at public meetings of the Board or its Committees.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Received by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

EXHIBIT "A"

DISTRICT HOSPITAL CAMPUS

ATTACHED

Audit, Compliance & Ethics Committee (No meeting held in July, 2015)

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

June 25, 2015 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on June 25, 2015.

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

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, M.D.
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Esther Beverly, VP/Human Resources
Dr. Scott Worman, Chief of Staff
Dr. Gene Ma, Chief of Staff Elect
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Schallock, called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

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

3. Public Comments – Announcement

   Chairman Schallock read the Public Comments section listed on the June 25, 2015 Regular Board of Directors Meeting Agenda.

   There were no public comments.

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

Chairman Schallock deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of the items listed on the June 25, 2015 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; three Reports Involving Trade Secrets; Conference with Legal Counsel regarding one matter of potential litigation; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding two matters of Existing Litigation; Approval of Closed Session Minutes and Public Employee Evaluation: Chief Executive Officer.

5. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Kellett to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:37 p.m. in Assembly Rooms 1, 2 and 3, Chairman Schallock announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Steve Dietlin, Chief Financial Officer
Sharon Schultz, RN, Chief Nurse Executive
Esther Beverly, VP, Human Resources
Dr. Scott Worman, Chief of Staff
Dr. Gene Ma, Chief of Staff Elect
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Schallock stated no action was taken in closed session, however the Board will be returning to closed session at the conclusion of this meeting to conduct unfinished business.

10. Chairman Schallock noted all Board members were present. Director Nygaard led the Pledge of Allegiance.

11. Chairman Schallock read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

Chairman Schallock announced that Dr. Gene Ma is seated at the Dais today and will be taking over as Chief of Staff, representing the Medical Staff for the next two years, effective July 1st.

12. Special Presentations:

(1) Ceremonial Presentation and Awarding of Community Healthcare Grant Awards

Chairman Schallock and Director Nygaard presented grant award checks to the Community Healthcare Grant award recipients for a total amount of $435,000 as follows:

Alzheimer's Association for San Diego/Imperial Chapter -
Funding for this project will support patients and their families impacted by Alzheimer's and dementia in the Tri-City region and the creation of a new early intervention and support program called Take Charge.

American Diabetes Association –
Funding for this project will provide diabetes awareness, prevention and management services to Latino families through education and testing.

BILY San Diego –
Funding for this project will provide educational materials needed to expand awareness of the BILY Parent Support Program throughout the Tri-City area.

Boys & Girls Club Carlsbad
Funding for this project will support staff for the Village Clubhouse and Amory Teen Center, a program that is offered free of charge to all local teens including those with disabilities.

Boys & Girls Club Oceanside –
Funding for this project will support staffing and supplies for the Wellness Warriors project, a year-round program designed to educate youth about nutrition, teach healthy eating habits and healthy cooking skills, incorporate daily fitness activities into programming and utilize technology to research health and nutrition topics.

Emilio Nares Foundation
Funding for this project will support transportation costs to ensure low income children with cancer have access to crucial medical appointments.

Fraternity House, Inc.
Funding for this project will support oversight of both Vista and Escondido sites. The Fraternity House is the only facility of its kind in San Diego County and ensures access to hospice care for indigent and low income terminally ill patients suffering from HIV/AIDS.

Hospice of the North Coast –
Funding for this project will assure access to quality end-of-life care and hourly hospice care for an estimated 250 terminal patients.

Impact Young Adults (YA) –
Funding for this project will provide staff support for this peer led support community for young adults, ages 18-35 with serious mental illness.

KOCT Oceanside Community TV Corporation -
Funding for this project will provide production equipment and technical assistance for the development and distribution of eighteen 30-minute *Community Health Matters* program videos to education and inform viewers about their health and accessibility to healthcare services.

New Haven Youth & Family Services –
Funding for this project will support staffing for the Center 4 Community Connections, a center that provides services to community youth diagnosed with severe mental illness.

North County LGBTQ Resource Center –
Funding for this project will provide mental health services and counseling to LGBTQ families and youth to enhance mental health services to address the high risk of suicide and substance abuse that affects the LGBTQ community.

North County Lifeline –
Funding for this project will provide strength based parenting and education to 200 Tri-City parents whose children have been diagnosed with mental health disorders by providing early intervention and treatment for severe emotional illnesses.

Operation Hope, Vista –
Funding for this project will provide funding for intake evaluations of 50 adult clients by a TIR therapist and aid staff in identifying a client's mental health barriers and subsequently offer the client either a more in depth mental health referral or inside certified Trauma incident Reduction therapy.

Parkinson's Association of San Diego –
Funding for this project will support the opening of a new North County office that will provide services to people with Parkinson's Disease, their families and caregivers, through referral, evidence based education, transportation, diet, nutrition, exercise, support and counseling.

San Diego County Medical Society Foundation –
Funding for this North County CRC Collaborative project will provide colorectal cancer diagnostic services and treatment for low-income, uninsured residents.

Solutions for Change –
Funding for this project will support mental health services for homeless children through support of a case manager and enable them to pursue a plan and a path to escape multi-generational cycles of homelessness.

Vista Community Clinic –
Funding for this project will support development of an advanced Medical Assistant Training Program to assist the Clinic with its service to low-income and uninsured North County residents.

Women's Resource Center –
Funding of this project will help sustain the children's counseling program which will address the trauma for children involved in domestic violence.

Wounded Warriors Homes, Inc. –
Funding of this project will support transitional housing for medically discharged single veterans diagnosed with traumatic brain injury and/or post traumatic stress who are potential victims of homelessness.

Chairman Schallock congratulated all the grant recipients and invited the Board for a group picture with the grant recipients.

Director Nygaard recognized the members of the Grant Review Panel I for their time and effort in reviewing the grants and ensuring the process was completed in a fair manner consistent with the guidelines.

(2) Recognition of Dr. Scott Worman, for his service as Chief of Staff July 1, 2013 – June 30, 2015.

On behalf of the Board of Directors and Tri-City Medical Center, Chairman Schallock presented Dr. Worman with a plaque recognizing his leadership over the past two years. Chairman Schallock stated that in addition to working as a physician Dr. Worman has devoted a significant amount of time as the Medical Staff Representative and we greatly appreciate his efforts.

(3) Certificates of Appreciation to the following community members for their service on the Audit, Compliance & Ethics Committee, Community Healthcare & Alliance Committee and Human Resources Committee.

a) Sydelle Gale – Human Resources Committee
b) Henry Halloway – Human Resources Committee
c) Robin Iveson – Community Healthcare & Alliance Committee -
d) Robert Knezek – Finance, Operations & Planning Committee
e) Carlo Marcuzzi – Audit, Compliance & Ethics Committee
f) William McGaughey – Finance, Operations & Planning Committee

Chairman Schallock explained we have community members on the majority of our Board committees and they are allowed to serve up to two two-year terms.

Chairman Schallock recognized Ms. Robin Iveson, Community Healthcare Alliance Committee (CHAC) member. Chairman Schallock stated Ms. Iveson has been on the CHAC Committee for two two-year terms and we very much appreciate her donating her time, interest and involvement both in the community and in the hospital.

Chairman Schallock recognized Mr. Carlo Marcuzzi. Chairman Schallock stated Mr. Marcuzzi served on the Audit, Compliance & Ethics Committee for two two-year terms with a background in finance and accounting and we appreciate his insight, input and knowledge.

In addition to those individuals, Chairman Schallock also recognized Ms. Sydelle Gale and Mr. Henry Holloway who served on the Human Resources Committee, Mr.

Robert Knezek and Mr. McGaughey who served on the Finance, Operations & Planning Committee. Chairman Schallock stated these individuals have all completed their terms and bring expertise and community interest beyond the board level and we appreciate that they give of their time to participate on these committees.

13. Report from Chief Executive Officer

Mr. Tim Moran, Chief Executive Officer expressed his appreciation to Dr. Worman and thanked him for his service. Mr. Moran stated he is confident the physician leadership will be in good hands with incoming Chief of Staff Dr. Gene Ma.

Mr. Moran stated Palomar has reported they will be closing their downtown facility in Escondido. Mr. Moran stated he does not know what if any ramifications there will be here for Tri-City however, it is Palomar's intent to transfer their Behavioral Health Unit to the Pomerado facility and reduce the number of beds. Mr. Moran extended his best wishes to Palomar for a successful move.

Mr. Moran reported Tri-City was one of only four hospitals in the county to receive an "A" rating from the Leapfrog Group for Patient Safety. He recognized Ms. Sharon Schultz and her staff for her efforts.

Lastly, Mr. Moran reported Tri-City has received for the second year in a row the Lifeline Gold-Plus Award which recognizes our quality outcomes related to Heart Attack and Stroke. Mr. Moran stated Tri-City is the only hospital in San Diego to receive this award.

No action was taken.

14. Report from Chief Financial Officer

Mr. Dietlin reported on the Fiscal YTD financial results as follows (dollars in Thousands):

- Net Operating Revenue – $308,004
- Operating Expense – $307,272
- EROE - $4,904
- EBITDA – $19,468

Other Key Indicators for the current year included the following:

- Average Daily Census – 192
- Adjusted Patient Days – 103,398
- Surgery Cases – 6,142
- Deliveries – 2,383
- ED Visits – 64,537

- Net Patient Accounts Receivable – $43.4
- Days in Net Account Receivable – 53.6
-

From an operating performance perspective, Mr. Dietlin reported the following for the current month (dollars in Thousands):

- Operating Revenue - $30,033
- Operating Expense - $28,713
- EBITDA - $3,136
- EROE - $1,814

Mr. Dietlin also presented graphs which reflected Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, Emergency Department Visits.

No action was taken.

15. New Business

a. Consideration to approve Resolution No. 773, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2015 and ending June 30, 2016, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California.

It was moved by Director Dagostino that the TCHD Board of Directors approve Resolution No. 773, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2015 and ending June 30, 2016, in accordance with Article XIIB of the Constitution of the State of California, Code of the State of California. Director Kellett seconded the motion.

Mr. Steve Dietlin commented each year we have the same resolution and this is a statutory requirement that sets an appropriation limit for the District. Mr. Dietlin explained it is a calculation that sets the maximum amount the District could collect in tax revenue and is based on cost of living and population statistics. Mr. Dietlin stated the appropriations limit for this year is $12,507,599. He emphasized that this is not the amount the District expects to collect but is the maximum amount that the allocation could be. In other words, Special Districts have an apportionment of the 1% property tax that is collected and the maximum Tri-City could receive is $12, 5 million.

Director Reno stated there are concerns in the community that this has to do with raising our costs. Mr. Dietlin clarified that this is not a new tax and it sets a limit on what the allocation could be. Mr. Dietlin stated he projects the district will receive $8.2 million this year.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration to close both Oceanside and Vista Nifty after Fifty programs, effective July 31, 2015

Mr. David Bennett, Chief Marketing Officer reported it is a recommendation of the leadership team to close both Nifty after Fifty locations on July 31st and donate equipment to senior citizen centers. He stated all members will be offered a six month's free membership at the Tri-City Wellness Center. Mr. Bennett explained the program is losing $50,000 per month and membership has not increased with the recent marketing campaign. Mr. Bennett further explained that it appears the program worked in the Orange County market due to mandated preferred providers for certain healthcare plans that referred their patients to Nifty After Fifty.

It was moved by Director Kellett that the TCHD Board of Directors authorize the closing of the Oceanside and Vista Nifty after Fifty programs as recommended by the Finance, Operations & Planning Committee. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Dagostino**
ABSENT:	**Directors:**	**None**

c. Consideration to appoint Mr. Carlo Marcuzzi to a two year term on the Finance, Operations & Planning Committee

It was moved by Director Reno that the TCHD Board of Directors appoint Mr. Carlo Marcuzzi to a two year term on the Finance, Operations & Planning Committee. Director Finnila seconded the motion.

Mr. Marcuzzi introduced himself. He stated he just completed his four-year term on the Audit, Compliance & Ethics Committee and is now applying for the Finance, Operations & Planning Committee. Mr. Marcuzzi stated he believes his experience personally and with the former committee will be a good fit and he welcomes the opportunity.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

d. Consideration to appoint Mr. Tim Keane to a two year term on the Finance, Operations & Planning Committee

It was moved by Director Dagostino that the TCHD Board of Directors appoint Mr. Tim Keane to a two year term on the Finance, Operations & Planning Committee. Director Nygaard seconded the motion.

Chairman Schallock stated Mr. Keane was unable to attend today's meeting, however his application and qualifications are included in today's agenda packet.

Director Reno stated she is all in favor of community members serving on our Board committees, however, she does not believe members should be selected through the use of a balloting system and that the District does not use the balloting system for any of the election process. Mr. Moser stated typically the balloting system is not used in a public agency, however if a balloting system is used the names of the people voting must be recorded so that it is a transparent process and individuals in the community attending the meetings understand who is voting which way on each item. Director Reno requested the policy on this process be clarified by the Governance Committee.

Director Dagostino explained the Chair chose to use balloting system as the committee was selecting two members and rank voting is allowed under the parliamentary procedure rules per Mr. Moser as long as it is a public opening. He explained that the ballots have the names of the voters, a teller was appointed who processed the rank voting and those ballots are attached to the committee minutes and are available for pubic purview.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

e. Consideration to appoint Ms. Virginia Carson to a two year term on the Employee Fiduciary Subcommittee

It was moved by Director Reno that the TCHD Board of Directors appoint Ms. Virginia Carson to a two year term on the Employee Fiduciary Subcommittee. Director Kellett seconded the motion.

Chairman Schallock stated Ms. Carson is not in attendance today, however she currently serves on the Human Resources Committee and that committee has recommended her appointment to the Employee Fiduciary Subcommittee.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

16. Old Business – None

17. Chief of Staff

Consideration of June 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on June 22, 2015.

It was moved by Director Dagostino to approve the June 2015 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on June 22, 2015. Director Reno seconded the motion.

Dr. Worman thanked the Board and Administration for all their support over the last couple of years. He stated it has been an honor to represent the Medical Staff here but also an eye opening experience as to how complex the issues that management and the Medical Staff have to deal with. Dr. Worman stated he appreciates the open, receptive dialogue he has had with Administration and is happy to pass the torch on to Dr. Ma.

Director Dagostino requested clarification as to why a physician with a degree in Audiology is sponsored by the Orthopedic Surgery Division. Director Dagostino also requested confirmation that Dr. Afra is in fact a Family Medicine physician.

In response to Director Dagostino's first question, Mr. Conley clarified that this particular Allied Health Professional is being sponsored by the Orthopedic Surgery Division. Dr. Johnson came to the podium and further explained that the Audiologist has specific training in nerve monitoring and monitors the integrity of the spinal cord in spine procedures.

Dr. Worman will follow-up on Director Dagostino's second question.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Consent Calendar

It was moved by Director Nygaard to approve the Consent Agenda. Director Kellett seconded the motion.

Director Finnila stated she would like to comment on the Audit Committee.

It was moved by Director Reno to pull item 18. (1) E. 2) Section 1 Emergency Operations Procedures Manual General Information and item 18 (1) G. 8), 9) and 10). It was moved by Director Dagostino to pull item 18. (1) D. 21. Approval of a new Hospitalist Services and On-Site Coverage Services Agreement with Coastal Hospitalists Medical Associations, Inc. and 18(1) D. 14. Approval of a renewal of an agreement with Drs. Frank Corona, Martin

Nielsen, Mark Yamanaka and Safouh Malhis for ICU Coverage Panel/ED Pulmonary On-Call Coverage. Director Kellett seconded the motions.

The vote on the main motion minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Discussion of items pulled from Consent Agenda

With respect to item 18 (1) D. 14. related to the Pulmonology Agreement, Mr. Kapua Conley clarified this is a new agreement rather than a renewal.

It was moved by Director Dagostino to approve the <u>new</u> agreement with Drs. Frank Corona, Martin Nielsen, Marks Yamanaka and Safouh Malhis for ICU Coverage Panel/ED Pulmonary On-Call Coverage as described on today's agenda. Director Nygaard seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

With respect to item 18 (1) D. 21. Approval of a new Hospitalist Services and On-Site Coverage Services Agreement with Coastal Hospitalists Medical Association, Inc., Mr. Conley clarified as part of a procedural process he is requesting renewal of a co-medical directorship for Drs. Day and O'Brien and terms of their initial agreement remain the same. Director Dagostino further clarified we are referring to the amended contract that includes the education budget that was approved in theory at the Finance, Operations & Planning Committee. Director Dagostino questioned if it is necessary to change the language of the contract itself to include the names of the Medial Directors. Mr. Conley stated the Medical Directorship contracts are separate contracts and he is requesting approval of those contracts today. Director Dagostino stated the Directorship contracts will be put in the contract template format and the dollar amount will not change.

Director Reno questioned if the contract templates will remain the same. Mr. Conley confirmed the templates will remain the same.

It was moved by Director Kellett to approve item 18 (1) D. 21. Approval of a new Hospitalist Services and On-Site Coverage Services Agreement with Coastal Hospitalists Medical Association Inc. to include the education budget and Medical Directorship contracts with Drs. Day and O'Brien. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Reno who pulled item18 (1) E. 2) Emergency Operations Procedures Manual (formerly Disaster Manual) and 18 (1) G Policies numbered 8), 9) and 10) stated it is her opinion that these policies warrant Board involvement and should be relooked at when the Chief Compliance Officer is on board. Chairman Schallock suggested the policies be approved today as written and request that the Governance Committee determine oversight for these types of policies.

It was moved by Director Dagostino to approve item 18 (1) E. 2) Emergency Operations Procedures Manual Section 1 and 18 (1) G. Policies numbered 8), 9) and 10) as presented. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Finnila, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Director Finnila commented that Moss Adams has been retained to do the hospital's fiscal year audit. She stated Moss Adams provided the Audit Entrance Report at this month's meeting and they do not anticipate any material weakness.

Director Reno questioned if the agreement with Moss Adams to conduct the audit was a renewal. Mr. Dietlin explained the Board previously approved a one-year extension to Moss Adams and intends to do an RFI for audit preparation in the fall.

No action necessary.

20. Reports (Discussion by exception only)

21. Legislative Update

Chairman Schallock reported the Governor signed the 2015-16 state budget on June 24, 2015 and the Legislature continues to work on the Medi-Cal reimbursement issue.

22. Comments by members of the Public - None

23. Additional Comments by Chief Executive Officer

Mr. Moran did not have any additional comments.

24. Board Communications

Director Nygaard expressed her appreciation to Dr. Worman for the outstanding job he has done as Chief of Staff. She stated things have changed for the positive and she appreciates the job he has done.

Director Mitchell also expressed her appreciation to Dr. Worman for a job well done.

Director Reno echoed Director Nygaard's and Mitchell's comments to Dr. Worman.

Director Reno stated she attended the Auxiliary's Annual Awards & Installation Luncheon on June 20th in which the volunteers are honored for their time and commitment to the organization with hours totaling 385,000. Director Reno also commended the Auxiliary for their fundraising efforts which totals over $3 million for 2014.

Director Kellett also thanked Dr. Worman for his service and wished Dr. Ma success in his incoming role as Chief of Staff.

Director Kellett stated he also attended the Auxiliary's Annual Awards & Installation Luncheon where the top award went to an individual who has donated 14,000 hours of their time to Tri-City. Dr. Kellett stated the volunteers are among the nicest people in the Tri-City community.

Director Finnila explained the procedure one follows in donating their body to science. She referred individuals to the UCSD Department of Pathology and Pharmacy for assistance.

Director Finnila commented that there are two so called "silly" seasons which include election and union negotiations. She stated the hospital is currently in the midst of union negotiations and although tensions may run high this is completely normal and part of the negotiation process.

Director Dagostino echoed fellow Directors comments related to the Auxiliary's Annual Awards & Installation Luncheon which he also attended. He noted his colleagues said it all!

Director Dagostino gave kudos to Dr. Worman for a job well done and wished Dr. Ma success.

25. Report from Chairperson

Chairman Schallock commented on the wonderful work that is done by the Auxiliary and expressed his appreciation for the many hours they put in.

Chairman Schallock reported yesterday Mayor Woods invited Board members to be introduced to the community at the Oceanside City Council meeting. He expressed his appreciation to Mayor Woods for the invitation and stated he also enjoyed meeting the Oceanside Queen and her court.

Chairman Schallock reported the hospital will be participating in Oceanside's 4th of July parade which is scheduled for 10:00 a.m. on Saturday, June 27th. He invited everyone out to the celebration.

26. Oral Announcement of Items to be Discussion in Closed Session

Chairman Schallock reported the Board would be returning to Closed Session to complete unfinished closed session business.

27. Motion to return to Closed Session.

Chairman Schallock adjourned the meeting to closed session at 4:37 p.m.

28. Open Session

At 7:14 p.m. Chairman Schallock reported the Board was back in open session. All Board members were present.

29. Report from Chairperson on any action taken in Closed Session.

Chairperson Schallock reported no action was taken in closed session.

30. There being no further business Chairman Schallock adjourned the meeting at 7:14 p.m. to Tuesday, June 30, 2015 at 6:00 p.m.

_____
Larry Schallock, Chairman

ATTEST:

_____
Ramona Finnila, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR AN ADJOURNED REGULAE MEETING
OF THE BOARD OF DIRECTORS
June 30, 2015 - 6:00 o'clock p.m. (adjourned from June 25, 2015)
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

An Adjourned Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way, Oceanside, CA at 6:00 p.m. on June 30, 2015.

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

Director Jim Dagostino, DPT, PT
Director Ramona Finnila
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Tim Moran, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Steve Dietlin, Chief Financial Officer
Cheryle Bernard-Shaw, Chief Operations Officer
Wayne Knight, SVP
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman Director Schallock, reconvened the adjourned meeting of June 25, 2015 to order at 6:04 p.m. in Classroom 6 with attendance as listed above.

5. Chairman Schallock adjourned the meeting to Closed Session at 6:04 p.m.

6. The Board returned to Open Session at 7:31 p.m. All Board members were present.

7. Report from Chairperson on any action taken in Closed Session.

   Chairman Schallock reported no action was taken in closed session.

8. There being no further business, Chairman Schallock adjourned the meeting at 7:31 p.m.

_____
Larry W. Schallock
Chairman

ATTEST:

_____
Ramona Finnila
Secretary

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Questions: jennifer.parrucci@corporatecompliance.org

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September 14–17 • Chicago, IL

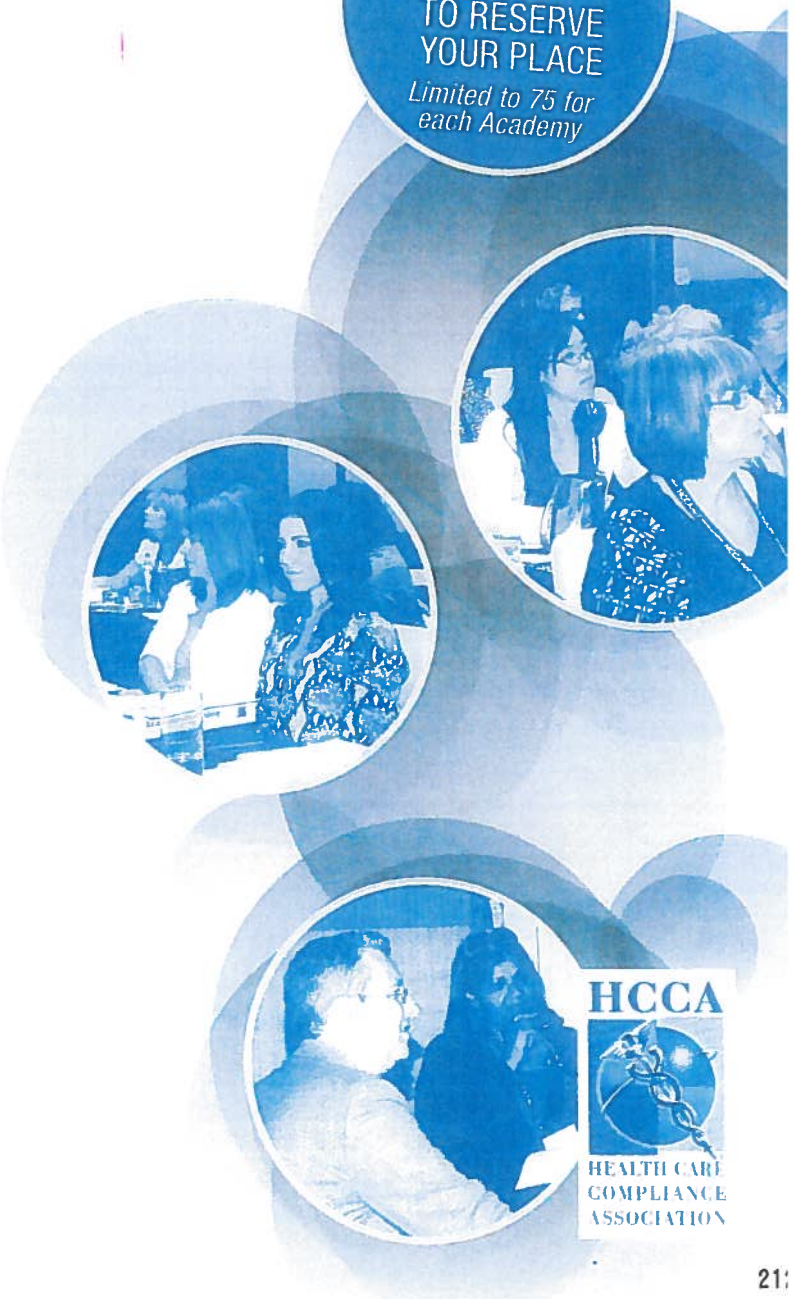
Sep 28–Oct 1 • Scottsdale, AZ

October 19–22 • Las Vegas, NV

October 26–29 • Nashville, TN

November 16–19 • Orlando, FL

Nov 30–Dec 3 • San Diego, CA



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Member id (if applicable)

First MI

Last

Credentials

Job title

Name of employer

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Country

Phone Fax

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5 or more: $200 discount for each registrant
10 or more: $400 discount for each registrant

Discounts take effect the day a group reaches the discount number of registrants. Please send registration forms together to ensure that the discount is applied. A separate registration form is required for each registrant. Note that discounts will NOT be applied retroactively if more registrants are added at a later date, but new registrants will receive the group discount.

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Please make your check payable to HCCA. Enclose payment with your registration and return it to the HCCA office, or fax your credit card payment to 952-988-0146. Payment must be sent in at least two weeks prior to the start date or your space may be released. If your total is miscalculated, HCCA will charge your card the correct amount. For information on group discounts, please see the box on the registration form. The cost of any exams and the hotel accomodations are not included in the registration fee. Breakfast and lunch are included in the tuition amount where indicated in the agenda. The CHC exam application form must be faxed or mailed as indicated on the form.

Cancellations/Substitutions: You may send a substitute in your place or request a conference credit. Conference credits are issued in the full amount of the registration fees paid and are good for 12 months from the date of the cancelled event. Conference credits may be used towards any HCCA service. If you need to cancel your participation, notify us prior to the start date of the event by email at helpteam@hcca-info.org or by fax at 952-988-0146. Please note that if you are sending a substitute, an additional fee may apply.

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~~June 8–11 | Scottsdale, AZ~~ ***SOLD OUT***

☐ August 10–13 | New York, NY ***LIMITED SEATS REMAIN***
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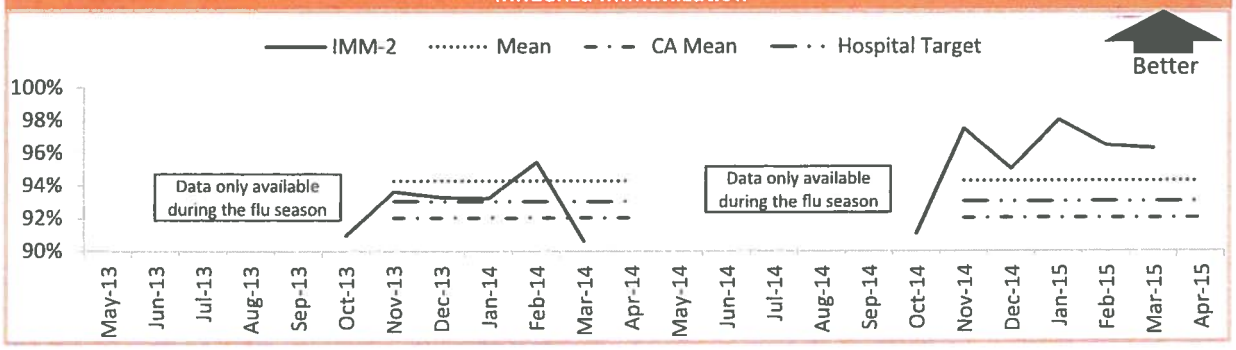
CAL0415 / CAM0615 / CAU0815 / CAA0915 / CAA22015 / CAO1015 / CAO22015 / CAF1115 / CAD1215

Process of Care Measures (Core Measures)

Centers for Medicare & Medicaid (CMS)

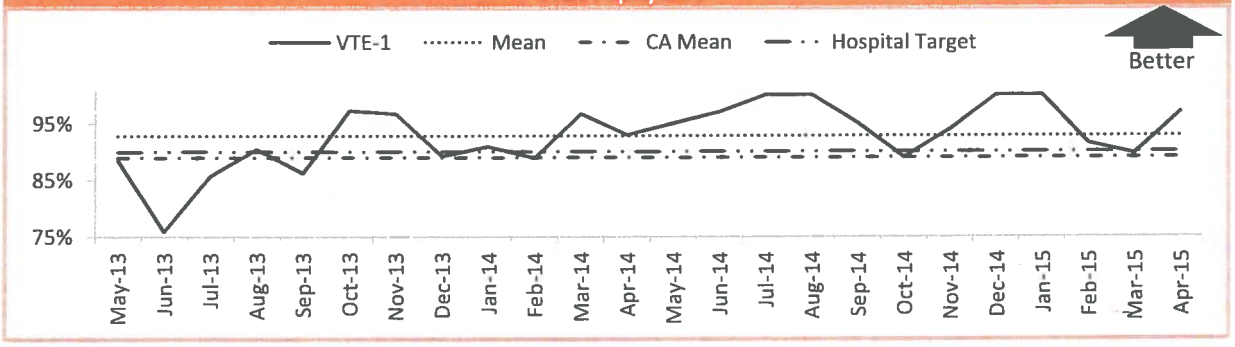
Influenza Immunization



Action Plan

Continue to monitor

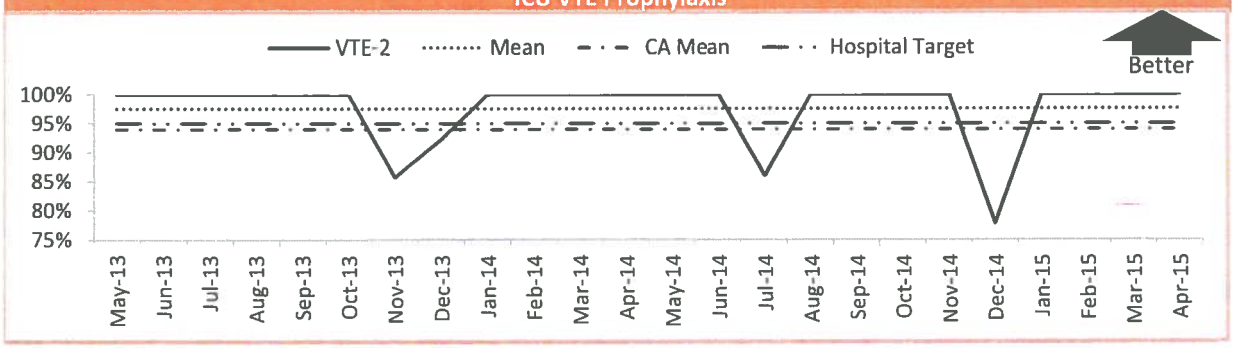
VTE Prophylaxis



Action Plan

Continue to monitor

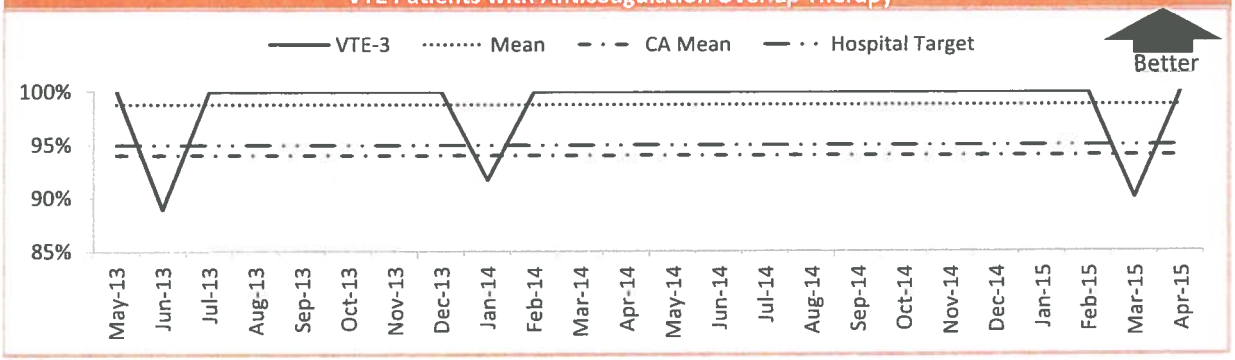
ICU VTE Prophylaxis



Action Plan

Continue to monitor

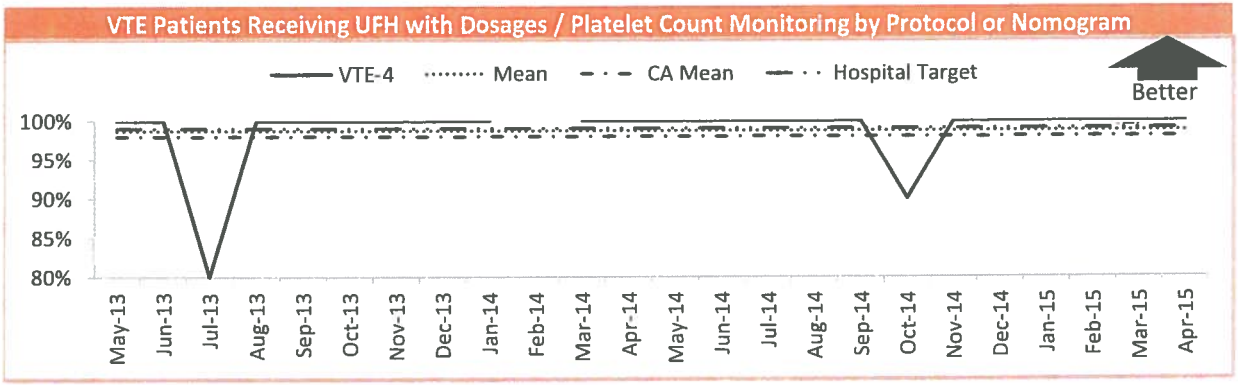
VTE Patients with Anticoagulation Overlap Therapy



Action Plan

Continue to monitor

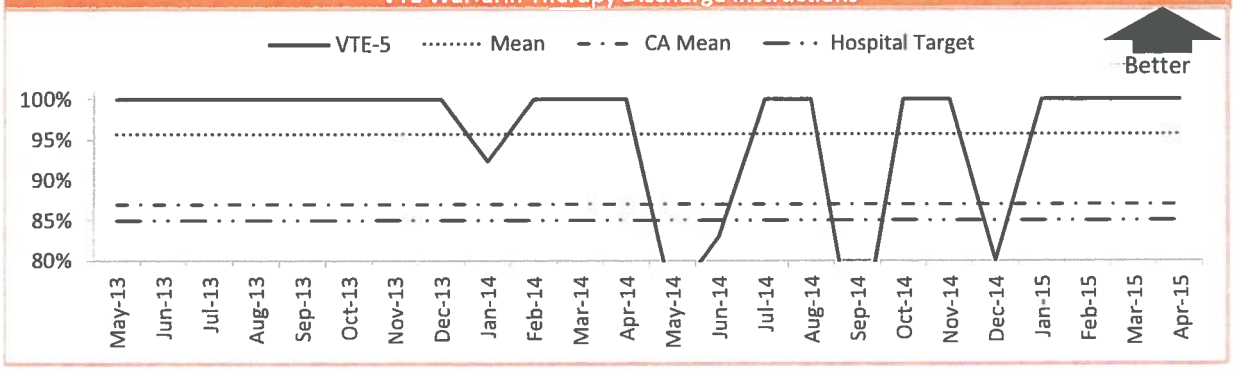
VTE Patients Receiving UFH with Dosages / Platelet Count Monitoring by Protocol or Nomogram



Action Plan

Continue to monitor

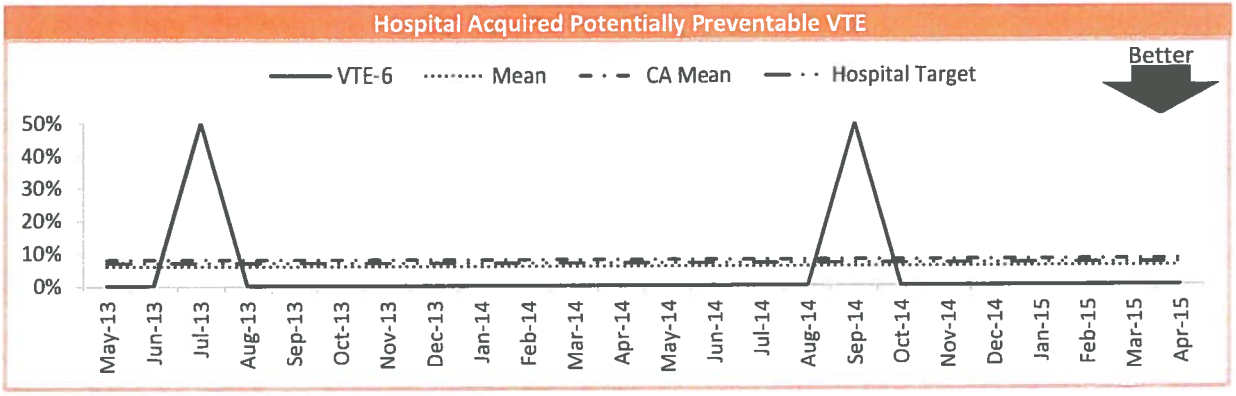
VTE Warfarin Therapy Discharge Instructions



Action Plan

Continue to monitor

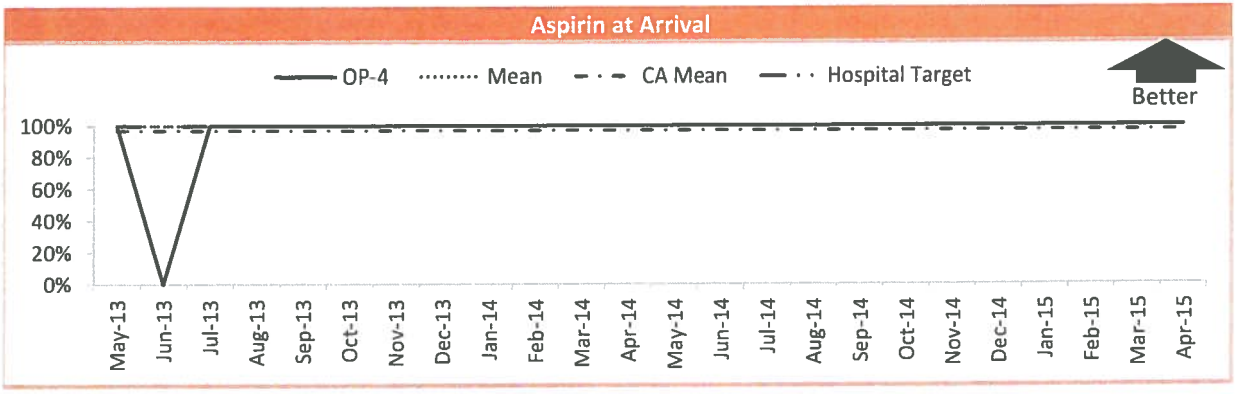
Hospital Acquired Potentially Preventable VTE



Action Plan

Continue to monitor

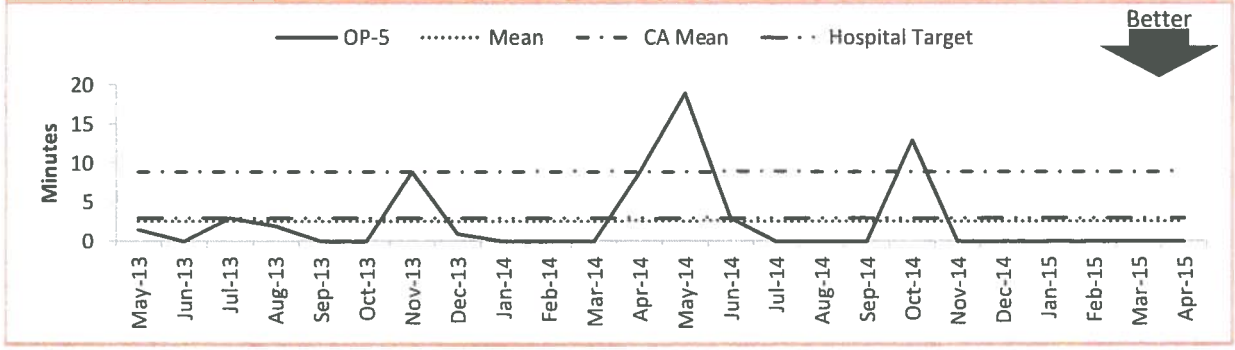
Aspirin at Arrival



Action Plan

Continue to monitor

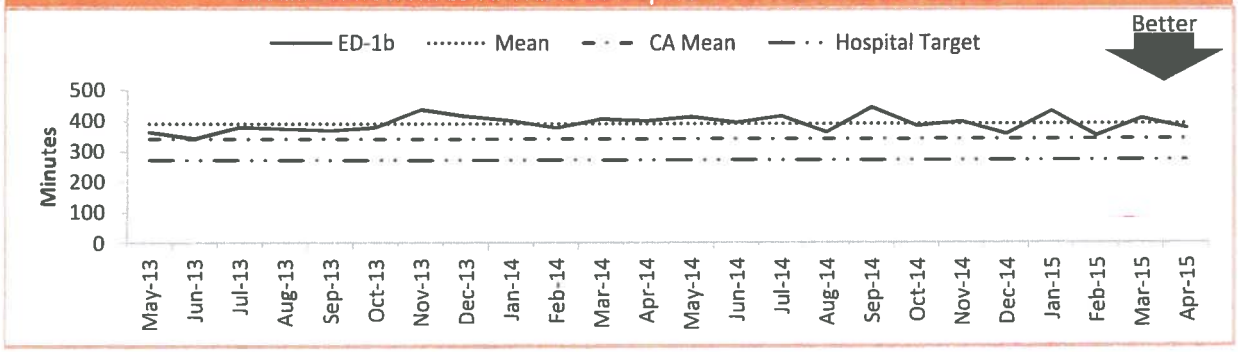
Median Time to ECG



Action Plan

Continue to monitor

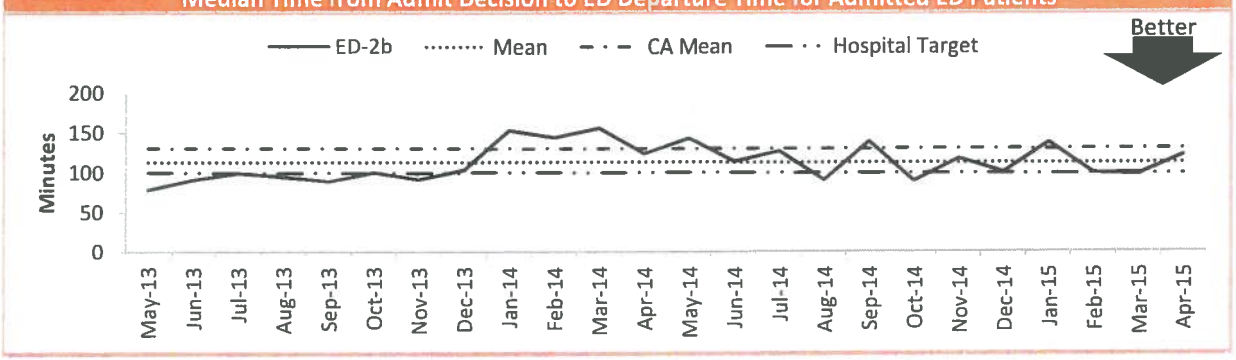
Median Time from ED Arrival to ED Departure for Admitted ED Patients



Action Plan

Continue to monitor

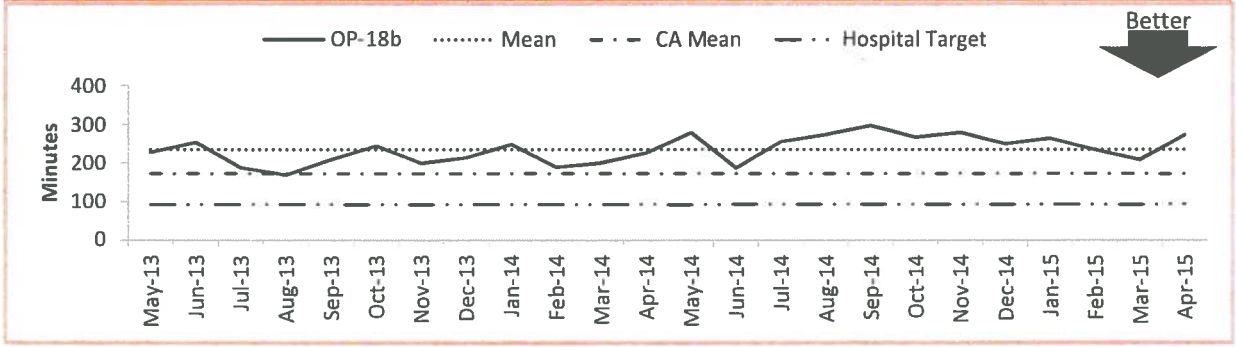
Median Time from Admit Decision to ED Departure Time for Admitted ED Patients



Action Plan

Continue to monitor

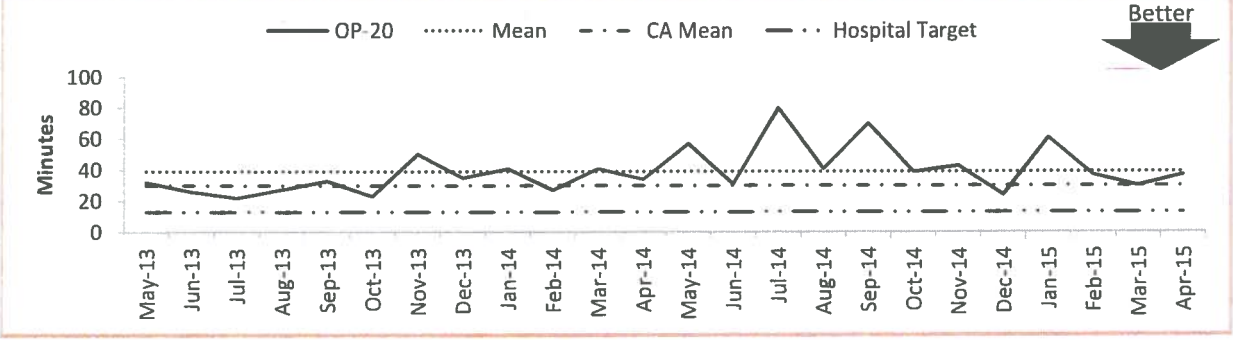
Median Time from ED Arrival to ED Departure for Discharged ED Patients



Action Plan

Continue to monitor

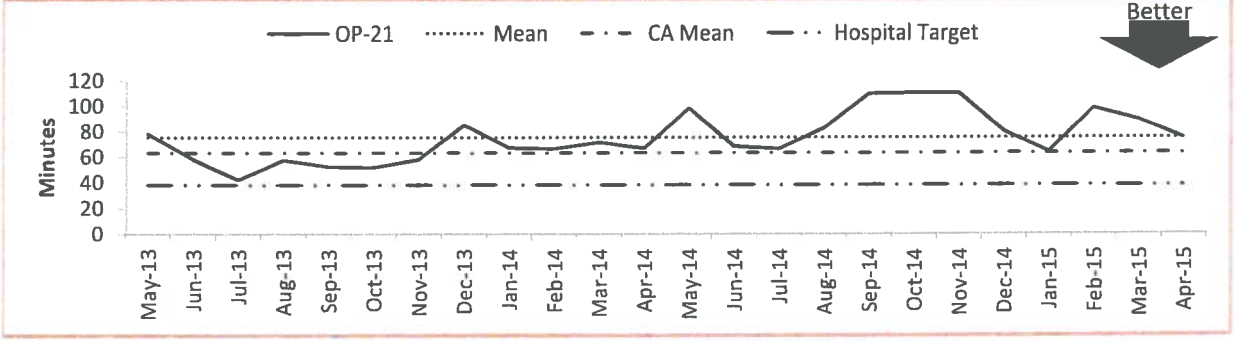
Median Time from ED Arrival to Provider Contact for ED Discharged Patients



Action Plan

Continue to monitor

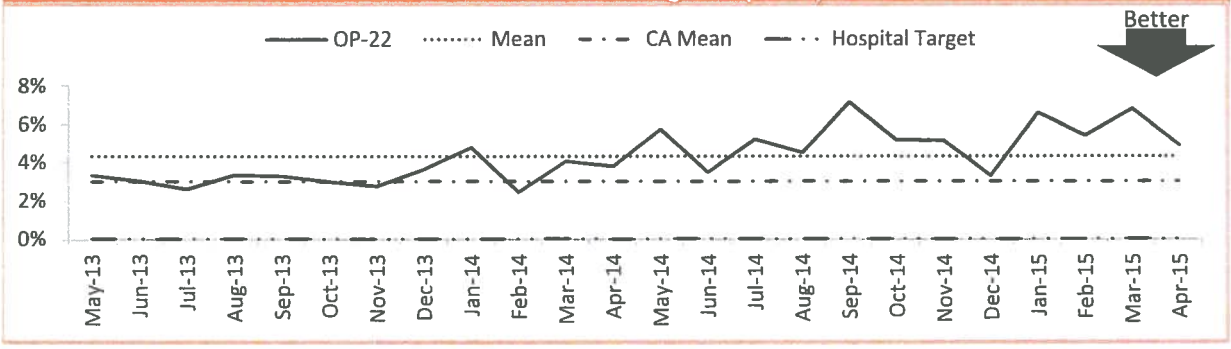
Median Time to Pain Management for Long Bone Fracture



Action Plan

Continue to monitor

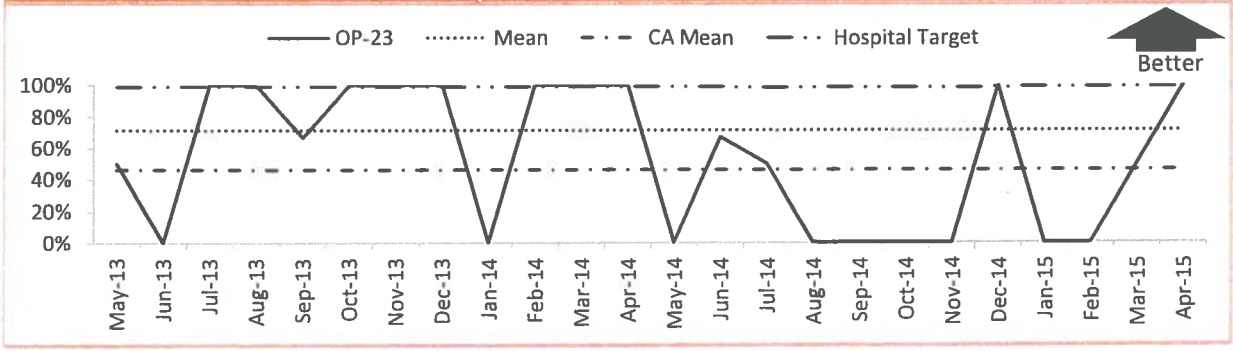
Patient Left Before Being Seen (LWOT)



Action Plan

Continue to monitor

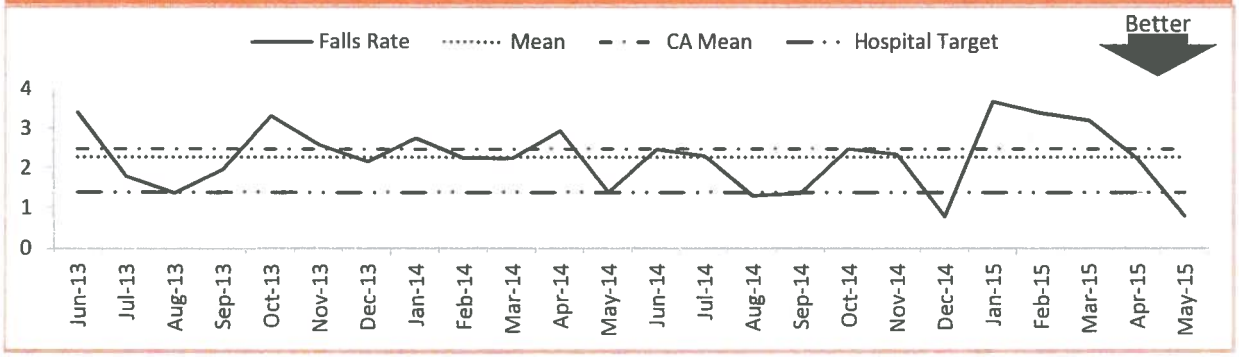
Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 minutes of ED Arrival



Action Plan

Continue to monitor

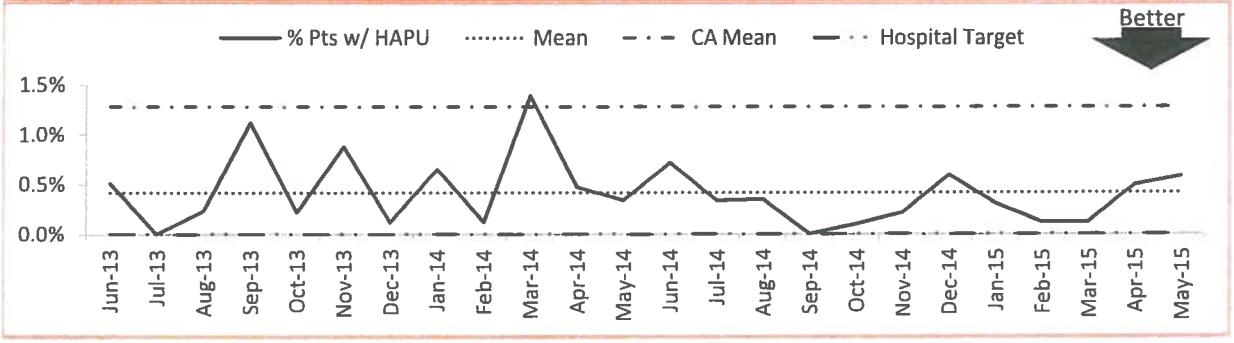
Hospital Wide Falls Rate Per 1000 Pt Days



Action Plan

Continue to monitor

Hospital Wide % Patients with HAPU



Action Plan

Increase Skin & Wound Champions on all units (model after Telemetry)
Created workgroup with tool to determine if HAPU is Avoidable vs. Unavoidable
Continue with HAPU Case Reviews
Continue with mandatory yearly RN Wound Class
Implementation of PowerPlans for standardized wound care per policy

Control Chart Interpretation

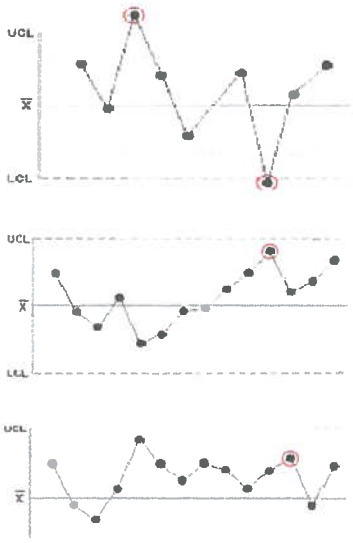
Legend

- Hospital Mean
- Hospital Rate
- Hospital UCL
- CA Mean

Hospital Mean is the average value we can expect based on the data collected.

Hospital Rate is the actual value.

Hospital UCL (Upper Control Limit) is the highest level of quality that is still considered "normal" given the data history. It is usually 3 standard deviations from the mean.



Description	Indication
One point is more than 3 standard deviations (UCL) from the mean.	One sample (two shown in this case) is grossly out of control.
Six (or more) points in a row are continually increasing (or decreasing).	A trend exists. Procedures in place have an effect on outcomes either positive or negative.
8 (or more) points in a row are on the same side of the mean	Some prolonged bias exists.

Employee Satisfaction

Partnership™
"Satisfaction + Engagement"
Mean = 66.1 (-1.0)
Percentile = 28th (from 13th)

Satisfaction
"what do I get?"
Mean = 61.9 (-1.2)
Percentile = 27th (from 13th)

Engagement
"what do I give?"
Mean = 71.8 (-0.6)
Percentile = 31st (from 12th)

National 90th Mean Scores

Partnership:	79.9
Satisfaction:	77.1
Engagement:	83.6

- Voluntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			9.9%			10.2%			10.8%			11.4%	11.4%
FY14			12.7%			12.7%			11.7%			11.8%	11.8%

Involuntary Employee Turnover Rate (Annual Rate - Rolling Quarters)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY15
FY15			1.9%			2.3%			3.3%			3.6%	3.6%
FY14			8.6%			8.4%			6.8%			3.2%	3.2%

HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

Benchmark Source: Hospital Compare
Benchmark Period: 7/1/2013-6/30/2014

"Overall Rating of Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	66%	60%	61%	57%	62%	61%	71%	55%	61%	58%	60%			70%	78%	73%	77%	68%	71%
FY14	60%	63%	58%	71%	65%	75%	61%	64%	64%	63%	65%	59%	64%						

"Recommend The Hospital"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	73%	69%	66%	61%	57%	61%	65%	63%	60%	63%	64%			76%	80%	78%	81%	70%	71%
FY14	63%	67%	67%	78%	65%	77%	65%	69%	65%	61%	72%	64%	68%						

Performance compared to prior year: Better | Same | Worse

"Communication with Nurses"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	79%	77%	72%	71%	69%	75%	78%	66%	73%	69%	78%			78%	79%	78%	82%	75%	79%
FY14	76%	72%	74%	84%	73%	81%	74%	76%	68%	69%	73%	75%	74%						

"Communication with Doctors"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	80%	71%	77%	75%	76%	76%	80%	78%	76%	75%	79%			79%	82%	83%	82%	78%	82%
FY14	75%	75%	78%	79%	80%	85%	73%	77%	73%	75%	80%	81%	78%						

"Response of Hospital Staff"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	63%	76%	74%	62%	62%	72%	71%	52%	62%	57%	73%			63%	62%	66%	65%	62%	68%
FY14	63%	65%	66%	72%	69%	73%	64%	62%	61%	64%	68%	56%	65%						

"Hospital Environment"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	60%	57%	53%	55%	59%	59%	59%	57%	57%	56%	57%			60%	67%	65%	63%	61%	68%
FY14	54%	53%	56%	59%	58%	59%	62%	62%	55%	56%	62%	64%	58%						

"Pain Management"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	74%	68%	68%	66%	64%	69%	72%	68%	62%	62%	75%								
FY14	75%	60%	73%	76%	71%	76%	75%	70%	63%	60%	66%	64%	68%	71%	72%	71%	76%	69%	71%

"Communication about Medicines"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	65%	63%	59%	64%	56%	54%	62%	56%	60%	58%	52%								
FY14	65%	64%	61%	62%	56%	69%	65%	53%	55%	52%	62%	62%	60%	64%	64%	65%	66%	62%	65%

"Discharge Information"

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	FY	Scripps Encinitas	Palomar	UCSD	Scripps La Jolla	California Avg	National Avg
FY15	88%	81%	86%	85%	82%	84%	88%	88%	91%	83%	87%								
FY14	85%	80%	76%	84%	79%	88%	80%	77%	86%	80%	89%	86%	83%	83%	83%	88%	85%	84%	86%

Performance compared to prior year: Better Same Worse

Building Operating Leases
Month Ending June 30, 2015

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
Gary A. Colner & Kathryn Ainsworth-Colner Family Trust 4913 Colusa Dr. Oceanside, Ca 92056 V#79235	1,650	$1.85	(a)	$ 4,149.39	8/1/12	7/31/15	**Dr Dhruvil Gandhi** 2095 West Vista Way,Ste.106 Vista, Ca 92083	8460
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.50	(a)	$ 18,600.00	2/1/15	10/31/18	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA	7090
Tri-City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	$ 232,282.00	7/1/13	6/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009	7760 - 90.65% 7597 - 4.86% 7777 - 4.49% 9520 - 77.25% 7893 - 12.53%
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.50	(a)	$ 3,398.15	1/1/13	12/31/15	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056	8756
Golden Eagle Mgmt 2775 Via De La Valle, Ste 200 Del Mar, CA 92014 V#81553	4,307	$0.95	(a)	$ 6,028.77	5/1/13	4/30/18	**Nifty After Fifty** 3861 Mission Ave, Ste B25 Oceanside, CA 92054	9551
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.65	(a)	$ 9,126.93	9/1/12	8/31/17	**OP Physical Therapy, OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054	7772 - 76% 7792 - 12% 7782 - 12%
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 #43849	7,247	$1.22	(a)	$ 9,811.17	7/1/11	7/1/16	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 V#81250	4,760	$3.55	(a)	$ 22,900.00	10/1/12	10/1/22	**Chemotherapy/Infusion Oncology Office** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 irvine, CA 92663 V#81503	3,307	$1.10	(a)	$ 4,936.59	10/28/13	3/3/18	**Nifty after Fifty** 510 Hacienda Drive Suite 108-A Vista, CA 92081	9550
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		$ 7,908.20	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056	8462 Until operational
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		$ 12,736.83	1/1/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056	8462 Until operational
Total				**$ 331,878.03**				

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

Education & Travel Expense
Month Ending June 30, 2015

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	NATIONAL TEACHING INSTITUE	42115	630.00	80109	KERRY MCCRAY
6150	PROGRESSIVE CARE CERT	61515	175.00	82458	MELISSA WARD
6171	CANCER BASICS COURSES	38396	792.00	49112	NURSING STAFF
6185	CANCER BASICS COURSES	38396	1,029.60	49112	NURSING STAFF
7290	TUITION REIM	82449	230.28	82449	CHRISTEN FARRELL
7770	CERTIFY CLINICAL	32515	275.94	82442	JEANETTE WRIGHT
7782	WRITING FUNCTIONAL GOALS	40815	229.00	82405	SHAWN MARINKOVICH
7792	AM OCCUP THERAPY	21615	436.00	82455	ABBY MARCATO
8402	PURCHASING GROUP ORG	53115	239.68	81163	THOMAS MOORE
8510	DISTRICT HSP LEADERSHIP MEETING	52715	394.99	81508	STEVEN DIETLIN
8620	ACHD LEGISLATIVE CONFERENCE	52615	217.50	81380	JULIANNE L NYGAARD
8620	ACHD ANNUAL MEETING	51915	575.88	81380	JULIANNE L NYGAARD
8620	AHA LEGISLATIVE MEETING	61115	613.88	78591	LARRY W. SCHALLOCK
8620	ACHD ANNUAL MEETING	51915	1,485.06	82269	LAURA E MITCHELL
8620	AHA ANNUAL MTG/CHA CONGRESSIONAL CONF	51915	1,929.49	81515	JAMES DAGOSTINO
8620	AHA ANNUAL MTG/CHA CONGRESSIONAL CONF	52815	2,428.40	78591	LARRY W. SCHALLOCK
8700	MEDICARE BOOT CAMP	40915	1,699.00	31497	NURSING STAFF
8710	CAMSS FORUM	52615	476.02	77760	MARLA KOZINA
8740	CARING FOR LOW BIRTH	61915	100.00	82417	MARGAUX CARRILLO
8740	CARING FOR LOW BIRTH	61915	100.00	82457	SARAH ROBERTSON
8740	MOTIVATION IN SUBS ABUSE TRMT	60415	112.00	71410	TONY VITRANO
8740	LAW AND ETHICS	51515	125.00	48897	LYNETTE OHLSON
8740	PULMONARY REHAB	60415	125.00	46514	VALERIE NAEGELE
8740	ACLS	61915	133.00	77564	GAIL HART
8740	PHARMACOLOGY	61915	144.00	10891	WENDY BALDUF
8740	911 CONFERENCE	51515	145.00	66774	FLORA TOMOYASU
8740	ADVANCED CARDIAC LIFE SUPPORT	61915	150.00	77430	KAY ANDERS
8740	COOL TOPIC IN NEONATOLOGY	61915	150.00	79916	TAMARA L BOLDUC
8740	ADVANCED MINDFULLNESS TECHNIQUES	61915	189.99	81769	KRISTINA DITULLO
8740	ACLS RENEWAL	51515	195.00	81490	CLAUDIA MOOREHEAD
8740	CASE MGMT CONFERENCE	51515	200.00	77566	TRACY WOLL
8740	STROKE CONFERENCE	51515	200.00	80796	AMBER FLICK
8740	ADVANCED FETAL	51515	200.00	82430	DENA BETZ
8740	HCMA SEMINAR	52115	200.00	18668	KIRK CONELEY
8740	NATIONAL TEACHING INSTITUE	52115	200.00	80572	ELIZABETH FLEMING
8740	CRITICAL CARE EXPO	60415	200.00	77785	MONICA MILLER
8740	LACTATION CONFERENCE	60415	200.00	78048	TERESA MEDINGER
8740	CRITICAL CARE EXPO	60415	200.00	79454	SIRIRATN TILAKAMONKUL
8740	CRITICAL CARE EXPO	60415	200.00	81426	OLIVIA SANTILLAN
8740	NTI 2015	60415	200.00	82440	ANTHONY SCOTT
8740	NTI CONFERENCE	61915	200.00	77715	JESSICA MARTIN
8740	NTI CRITICAL CARE NURSING	61915	200.00	78850	JOHN C. WALKUP
8740	NTI CRITICAL CARE NURSING	61915	200.00	79441	JUANITA SAVENA
8740	CODE TRAUMA-CRITCAL	619152	200.00	78123	CAMILLE BRYAN
8740	ANIA 2015 NAT CONFERENCE	43015	958.80	67036	KATHY TOPP
8740	RN TO BSN	61915	1,816.59	82456	MARISA MARTINEZ
8740	BS IN HEALTHCARE	52115	2,000.00	80019	MICHAEL PARENT
8740	BSN	60415	2,000.00	78896	EMELY BOLSTON
8740	DEGREE IN NURSING	62615	2,000.00	82179	RYAN RABOLD
8740	RN TO BSN	61915	2,500.00	78123	CAMILLE BRYAN
8740	RN TO BSN	61915	2,500.00	81135	KRISTEN BAUMBACH
8740	RN TO BSN	61915	2,500.00	81807	EVA FROYD
8740	MSN FNP	61915	3,070.00	82454	NANCY CHEGE
8758	UCLA BRAIN ATTA	51815	296.78	79956	CAROL REELING

**This report shows payments and/or 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.