

**TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 26, 2026 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056**

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

<https://us02web.zoom.us/j/83056459961?pwd=jhfooR2uQgU19xyZLB5FI8rsw7cqIH.1>

**Meeting ID: 830 5645 9961
Passcode: 956366**

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	2 min.	Board Counsel
3	Roll Call / Pledge of Allegiance		
4	Approval of Agenda	2 min	Standard
5	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
6	Executive Reports	5 min.	COO/CNE/CIO/ Foundation President
7	January 2026 Financial Statement Results	10 min.	CFO
8	Old Business – None		
9	New Business a) Consideration to approve the exclusive Emergency Department On-Call coverage agreement for Neurosurgery between Tri-City Healthcare District and Sunil Jeswani, M.D., P.C., for a term of 12 months, beginning March 1, 2026 and ending February 28, 2027, with an annual cost not to exceed \$785,000.	5 min.	COO

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

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

	Agenda Item	Time Allotted	Requestor
10	Chief of Staff - a) Consideration of February 2026 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 23, 2026	5 min.	COS
11	Consent Calendar (1) Board Committee (a) Finance, Operations & Planning Committee Director Younger, Committee Chair 1) Approval of an agreement with the Department of the Navy to provide emergency medicine resident trainees for a term of 60 months, beginning April 1, 2026 and ending March 31, 2031. 2) Approval of the renewal of an agreement with Sunil Jeswani, M.D. for the Medical Directorship of the Neurosurgical program for a term of 12 months, beginning March 1, 2026 through February 28, 2027 for a total term cost not to exceed \$80,400. 3) Approval of Amendment One to Professional Services Agreement between Tri-City Healthcare District and North County Oncology Medical Clinic, for one year beginning March 1, 2026 and ending February 28, 2027 for a total base cost for the term not to exceed \$1,732,755. 4) Approval of the agreement with Ensign Group, LLC for a term of fifteen (15) years, beginning March 1, 2026 and ending February 28, 2041, for an estimated monthly cost of \$33,360. (2) Policies & Procedures a) Patient Care Services 1) Automatic External Defibrillator, Philips Policy 2) Candida Auris Screening Standardized Procedure 3) Chemotherapy Prescribing, Processing, and Preparation Policy 4) Consent for Operative or Other Procedures 359 5) Extended Dwell Catheter/Midline Catheter, Adults Procedure 6) Witnessing a Patient Signature on Patient's Personal Documents b) Administrative 200 District Operations 1) Medical Procedures and Interrogations Requested by Law Enforcement Policy 211 2) Quality Assessment Performance Improvement Plan c) Food & Nutrition 1) Nutrition Assessment and Care for Adult Geriatric Patients Policy 2) Nutrition Assessment and Care of High-Risk OB Patients Policy 3) Nutrition Care and Assessment for Infants, Pediatrics & Adolescents Policy d) Infection Control 1) Hand Hygiene 2) Infection Prevention Program Plan 3) Meningococcal Exposure IC 6.2	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	<p>4) Standard and Transmission-Based Precautions</p> <p>e) Mammography Women’s Center</p> <ol style="list-style-type: none"> 1) Communication of Results Women Center 2) Completion of Diagnostic Report 3) Diagnostic Mammography Policy 4) Mammography Image/Data Retention, Check-out and Copying 5) Mammography QA Plan DIT Policy 6) Screening Mammography Policy <p>f) Medical Staff</p> <ol style="list-style-type: none"> 1) Emergency Department Call: Duties of the On-Call Physician 8710-520 <p>g) Pharmacy</p> <ol style="list-style-type: none"> 1) Drug Product Procurement and Inventory Management Policy 2) Hours of Operation and Authorized Access to the Pharmacy <p>h) Pulmonary Rehab</p> <ol style="list-style-type: none"> 1) Patient Enrollment 2) Patient Referral <p>i) Radiology</p> <ol style="list-style-type: none"> 1) Radiologists Coverage Non-IR #125 <p>j) Rehabilitation</p> <ol style="list-style-type: none"> 1) Community Out-Reach Groups 2) Discharge Criteria 3) Documentation of Progress Note and Discharge Summary 4) Home Evaluation 5) Occupational Therapy Assistant Supervision 6) Occupational Therapy Policy 7) Outpatient Medical Records 8) Physical Therapy Assistant Supervision 9) Physical Therapy Policy 10) Referrals for Rehabilitation Services 11) Scope of Services 12) Supervision of Patient, Outpatient Policy 13) Supervision Requirements of Minors During Outpatient Rehabilitation 14) Therapeutic Recreation Department Policy <p>k) Rehabilitation Center</p> <ol style="list-style-type: none"> 1) Ethical Code of Conduct 2) Interdisciplinary Plan of Care 3) Interdisciplinary Team Conference 4) Mission Statement, Goals and Objectives 5) Patient/Family Conference 6) Policies and Procedures 7) Pre-Admission Screening 8) Provision of Services Not Provided by Tri-City Rehabilitation Center 9) Utilization Review Plan <p>l) Staffing</p> <ol style="list-style-type: none"> 1) Registry Badge Process Policy <p>m) Telemetry</p>		

	Agenda Item	Time Allotted	Requestor
	1) Monitoring Telemetry Patients Using the DASH 3000 2) Scope of Service 3) Weighing Telemetry Patients n) Ultrasound & Vascular Imaging 1) How to Report a Critical/Stat Read (3) Minutes a) Special Meeting – January 26, 2026 b) Special Meeting – January 29, 2026 c) Regular Meeting – January 29, 2026 d) Special Meeting – February 5, 2026 (4) Reports – (Discussion by exception only) a) Building Lease Report – (January, 2026) b) Reimbursement Disclosure Report – (January 26, 2026)		
12	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
13	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
14	Comments by Chief Executive Officer	5 min.	Standard
15	Board Communications	18 min.	Standard
16	Total Time Budgeted for Open Session	1 hour	
17	Adjournment		



Tri-City Medical Center

TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS

DATE OF MEETING: February 26, 2026

EXCLUSIVE EMERGENCY DEPARTMENT CALL COVERAGE AGREEMENT – NEUROSURGERY

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

Physician’s Name: Sunil Jeswani, M.D., P.C.

Area of Service: Neurosurgery

Term of Agreement: Beginning, March 1, 2026 through February 28, 2027

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

Rate/day	Quality Incentive up to:	Annual Cost
\$2,000	\$55,000	\$785,000

Description of Services/Supplies:

- Emergency Department Call Coverage

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

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

Motion:

I move that the that the TCHD Board of Directors authorize the approval of the exclusive Emergency Department On-Call coverage agreement for neurosurgery between Tri-City Healthcare District and Sunil Jeswani, M.D., P.C. for a term of 12 months, beginning March 1, 2026 and ending February 28, 2027, with an annual cost not to exceed \$785,000.



**TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT
February 11, 2026**

Attachment A

Initial Appointments

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

Medical Staff:

Practitioner Name	Specialty	Staff Status	Initial Appointment Term
BABKINA, Natalia MD	OB-GYN	Provisional	2/26/2026 - 2/26/2028
CIZMAR, Branislav MD	OB-GYN	Provisional	2/26/2026 - 2/26/2028
FADUL, Pamela Eva MD	Anesthesiology	Provisional	2/26/2026 - 2/26/2028
NAYER, Zacharia MD	Ophthalmology	Provisional	2/26/2026 - 2/26/2028
NISHIJIMA, Nicklaus DPM	Podiatry	Provisional	2/26/2026 - 2/26/2028
SHETH, Atul MD	Telepsychiatry	Provisional	2/26/2026 - 2/26/2028



**TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT - 1 of 1
FEBRUARY 11, 2026**

Attachment B

Reappointments:

Any items of concern will be "red" flagged in this report. The following practitioners were presented to members of the Credentials Committee for consideration for reappointment to the Medical Staff or Allied Health Professional Staff, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance. Reappointment is for 2-years unless otherwise noted below.

Medical Staff

Department of Medicine:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
AFRIDI, Faraz, MD	Critical Care	Active	02/26/2026-02/26/2028	Status change from Provisional to Active status.
BAROUDI, Sam, MD	Internal Medicine	Active	02/26/2026-02/26/2028	
DEVEREAUX, Christopher E, MD	Gastroenterology	Active	02/26/2026-02/26/2028	
GOMEZ, Denise Y, MD	Internal Medicine	Refer and follow	02/26/2026-02/26/2028	Status change from Active to Refer and follow, due to lack of activities.
TRAN, Quoc T, MD	Family Medicine	Refer and follow	02/26/2026-02/26/2028	
VORA, Shivani, MD	Critical Care	Refer and follow	02/26/2026-02/26/2028	Status change from Provisional to Refer and follow, due to lack of activities.
ZGLINIEC, Steven W, MD	Critical Care	Active	02/26/2026-02/26/2028	Status change from Provisional to Active status.

Department of Surgery:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
HANNA, Karen J, MD	General Surgery	Active	02/26/2026-02/26/2028	
NATARAJAN, Sabareesh, MD	Neurosurgery	Refer and follow	02/26/2026-02/26/2028	Status change from Provisional to Refer and follow, due to lack of activities.



TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
FEBRUARY 11, 2026

Attachment B

WHITE, Daniel V., MD	Neurosurgery	Active Affiliate	02/26/2026-02/26/2028	Status change from Provisional to Active Affiliate status.
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Department of Radiology:

Practitioner Name	Specialty	Staff Status:	Reappointment Term	Comments
PONEC, Donald J. MD	Interventional Radiology	Active	02/26/2026 - 02/26/2028	
GOODING, Justin M. MD	Interventional Radiology	Active	02/26/2026 - 02/26/2028	
PINNELL, Sean P. MD	Diagnostic Radiology	Active	02/26/2026 - 02/26/2028	

Resignations Medical Staff:

Practitioner Name	Department/Specialty	Reason for Resignation
ANAND, Neil MD	Radiology	Resignation letter received – Effective 02/28/2026
BOOKER, Michael MD	Radiology	Resignation Documentation received – Effective 02/28/2026
TSUKADA, Glenn H. MD	Radiology	Resignation Documentation received – Effective 02/28/2026
WONG, Felix MD	Radiology	Resignation Documentation received – Effective 02/28/2026
AVILA, Alfonso DO	Emergency Medicine	Resignation Documentation received – Effective 08/26/2024
GOMEZ, Jessica MD	Ophthalmology	Resignation Documentation received – Effective 03/31/2025
LAU, Yufei PAC	Critical Care Medicine	Resignation Documentation received – Effective 02/06/2026

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

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



**TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
February 11, 2026**

Addition/Deletion of Privilege(s)

The following practitioners have requested addition/deletion of privilege(s) as noted below. Effective February 26, 2026.

Practitioner Name	Department/Specialty	Change in Privilege/s
KIRBY, Hannah, MD	Orthopedic Surgery	Addition: Hand extensor, tendon repair.
HANNA, Karen J. MD	General Surgery	Deletion: Sedation Privileges



TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 11, 2026

Proctoring Recommendations

The following providers have successfully completed their initial FPPE (Focused Professional Practice Evaluation) and are being recommended for release of their proctoring requirements for the privilege(s) as noted below.

Practitioner Name	Department/Specialty	Privilege(s)
AFRIDI, Faraz, MD	Critical Care	<ul style="list-style-type: none">• Admitting, Consultation & H&P• General Critical Care Privileges
VORA, Shivani, MD	Critical Care	<ul style="list-style-type: none">• Admitting, Consultation & H&P• General Critical Care Privileges

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
February 18, 2026

Members Present	Director Tracy Younger (via teleconference), Director Adela Sanchez, Dr. Mohammad Jamshidi-Nezhad, Dr. Robert Lee, Dr. Henry Showah
Non-Voting Members Present:	Dr. Gene Ma, Jeremy Raimo, COO, CCO, Anh Nguyen
Others Present:	Benito Oporto, Director of Facilities, Miava Sullivan, FOP Coordinator, Jane Dunmeyer
Members Absent:	Director Nina Chaya

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Adela Sanchez called the meeting to order at 3:02 pm.		Chair
2. Approval of Agenda		<u>MOTION</u> It was moved by Dr. Henry Showah, seconded by Dr. Mohammad Jamshidi-Nezhad, and it was unanimously approved, with Director Chaya absent, to accept the agenda of February 18, 2026.	Chair
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Sanchez read the paragraph regarding comments from members of the public.	No comments	Chair
4. Ratification of minutes of December 3, 2025	Minutes were ratified.	Minutes were ratified. <u>MOTION</u> It was moved by Director Sanchez, seconded by Dr. Jamshidi-Nezhad, and it was unanimously passed, with Director Chaya absent, that the minutes of December 3, 2025, are to	Chair

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		be approved without any requested modifications.	
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:		<p><u>MOTION</u> It was moved by Dr. Jamshidi-Nezhad and seconded by Dr. Robert Lee and unanimously passed with Director Chaya absent, to approve the Consent Calendar</p> <p><u>Members:</u> AYES: Younger, Sanchez, Jamshidi-Nezhad, Lee, Showah NOES: None ABSTAIN: None ABSENT: Chaya</p>	Chair
a) ER Resident Agreement Renewal <ul style="list-style-type: none"> • Department of the Navy / Naval Medical Center, San Diego 		<u>Approved via Consent Calendar</u>	Donald Dawkins
b) Medical Directorship Agreement – Neurosurgery <ul style="list-style-type: none"> • Sunil Jeswani, M.D. 		<u>Approved via Consent Calendar</u>	Jeremy Raimo
c) Amendment One PSA 1206(B) <ul style="list-style-type: none"> • Pulmonary Specialist of North County, Inc. 	Revision forthcoming	<u>PULLED</u>	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
d) Amendment One PSA 1206(B) <ul style="list-style-type: none"> • North County Oncology Medical Clinic, Inc. 	An updated write-up was distributed to the group for consideration.	<u>Approved via Consent Calendar</u>	Jeremy Raimo
e) Distinct Part Skilled Nursing Facility Management Agreement Proposal <ul style="list-style-type: none"> • Ensign Group, Inc. 		<u>Approved via Consent Calendar</u>	Dr. Gene Ma
8. Financials	Anh Nguyen presented the financials ending January 31, 2026 (dollars in thousands) <u>TCHD – Financial Summary</u> <u>Fiscal Year to Date</u> Operating Revenue \$ 203,346 Operating Expense \$ 212,434 EBITDA \$ 14,993 EROE \$ 4,635 <u>TCMC – Key Indicators</u> <u>Fiscal Year to Date</u> Avg. Daily Census 124.1 Adjusted Patient Days 47,634 Avg Acute Length of Stay 4.93 Surgery Cases 2,950 ED Visits 28,519 <u>TCHD – Financial Summary</u> <u>Current Month</u> Operating Revenue \$ 31,121 Operating Expense \$ 31,802 EBITDA \$ 1,851 EROE \$ 426 <u>Graphs:</u> <ul style="list-style-type: none"> • TCHD-EBITDA and EROE • TCMC-Average Daily Census, Total Hospital - Excluding 		Anh Nguyen

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	Newborns <ul style="list-style-type: none"> • TCMC-Acute Average Length of Stay • TCMC-Productive Full Time Equivalents-13 Month Trend • TCMC-Paid Full Time Equivalents-13 Month Trend 		
a. Dashboard	No discussion	Information Only	Anh Nguyen
9. Comments by Committee Members	None	None	Chair
10. Date of next meeting	March 18, 2026		Chair
11. Adjournment	Meeting adjourned 3:25 p.m.	It was moved by Dr. Sanchez and seconded by Dr. Jamshidi-Nezhad and unanimously passed with Director Chaya absent, to adjourn the meeting at 3:25 p.m.	Chair



Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: February 18, 2026

Naval Medical Center, San Diego - ER Resident Agreement Renewal Proposal

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

Vendor's Name: Department of the Navy / Naval Medical Center, San Diego

Area of Service: Emergency Medicine

Term of Agreement: 60 months, Beginning, April 1, 2026 – Ending, March 31, 2031

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
\$0	\$0	\$0

Description of Services/Supplies:

- No cost / expense to TCHD
- Provide Resident(s) trainee per rotation, number and assignment to be mutually agreed upon between Naval Medical Center, San Diego and TCMC Emergency Medicine Residency Coordinator, currently Bismark Oh, M.D.
- SD Naval Medical Center Trainee(s) will be supervised by the TCMC Emergency Medicine Physicians
- There will be no training expense
- TCMC will not use (SDNMC) trainees or faculty in any publicity
- TCMC will generate bills for services rendered by the trainees

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

Person responsible for oversight of agreement: Jonathan Gonzalez, Director-Medical Staff Services / Donald Dawkins, Chief Nurse Executive

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the agreement in which The Department of the Navy to provide emergency medicine resident trainees for a term of 60 months, beginning, April 1, 2026 and ending, March 31, 2031.



Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: February 18, 2026

MEDICAL DIRECTORSHIP AGREEMENT – NEUROSURGERY

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

Physician’s Name: Sunil Jeswani, M.D.

Area of Service: Neurosurgery

Term of Agreement: Beginning, March 1, 2026 through February 28, 2027

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

Rate/Hour	Hours Per Month	Hours Per Year	Monthly Cost	Annual Cost
\$335	20	240	\$6,700	\$80,400

Description of Services/Supplies:

- Medical Direction of Neurosurgical services
- Develops, implements and monitors neurosurgical services to ensure patient care quality and regulatory compliance.

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize a renewal medical directorship agreement with Sunil Jeswani, M.D. for the Neurosurgical program for a term of 12 months, beginning, March 1, 2026 through February 28, 2027 for a total term cost not to exceed \$80,400.



Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: February 18, 2026

AMENDMENT ONE TO PROFESSIONAL SERVICES AGREEMENT - 1206(B) ONCOLOGY CLINIC

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

Vendor's Name: North County Oncology Medical Clinic, Inc.

Area of Service: Ambulatory Oncology Clinic

Term of Agreement: One Year, March 1, 2026 through February 28, 2027

Maximum Totals for Base Compensation:

Retention Stipend	Monthly Cost	Annual Base Cost	Total Term Base Cost
\$195,000	\$128,146	\$1,537,755	\$1,732,755

Description of Services/Supplies:

- Ambulatory clinic coverage for both inpatient and outpatient oncology and infusion services
- Per WRVU rate above the base cost reimbursed to group for productivity above base threshold

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

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

Motion:

I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the Amendment One to Professional Services Agreement Tri-City Healthcare District and North County Oncology Medical Clinic, Inc for a 12 month term, beginning March 1, 2026 and ending February 28, 2027 for a total base cost for the term not to exceed \$1,732,755.



Tri-City Medical Center

FINANCE, OPERATIONS & PLANNING COMMITTEE

DATE OF MEETING: February 18, 2026

PROPOSAL: Distinct Part Skilled Nursing Facility Management Agreement

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

Vendor's Name: Ensign Group, Inc
Area of Service: Distinct Part Skilled Nursing Facility
Term of Agreement: March 1, 2026 through February 28, 2041
Maximum Totals:

Estimated Monthly Cost
\$33,360

Description of Services/Supplies:

- Management agreement with Ensign Group to operate and manage a distinct part skilled nursing facility (SNF) on the TCMC campus
- Monthly cost is an estimate based on 5% of gross collections
- Manager (Ensign Group) assumes full operational and financial responsibility in excess of initial capital expenditures and the monthly service fee
- TCMC is entitled to rent credits as landlord, estimated to be \$720,000 per year (lease agreement to follow)
- TCMC is entitled to 25% of the Facility's monthly net income, while Ensign is entitled to 75% of the Net Income
- TCMC is responsible for 25% of the initial capital expenditures, while Ensign is responsible for 75% of the initial capital expenditures, currently estimated to be \$1.2 million in order to make the necessary renovations to meet distinct part SNF standards

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

Person responsible for oversight of agreement: Gene Ma, CEO

Motion:

I move that Finance Operations and Planning Committee recommend that the TCHD Board of Directors authorize the management agreement with Ensign Group, LLC for a term of fifteen (15) years, beginning March 1, 2026 and ending February 28, 2041, for an estimated monthly cost of \$33,360.



ADMINISTRATION CONSENT AGENDA

February 18, 2026

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Automatic External Defibrillator, Philips Policy	3-year review, practice change	Forward to BOD for Approval
2. Candida Auris Screening Standardized Procedure	NEW	Forward to BOD for Approval
3. Chemotherapy Prescribing, Processing, and Preparation Policy	3-year review, practice change	Forward to BOD for Approval
4. Consent for Operative or Other Procedures 359	3-year review, practice change	Forward to BOD for Approval
5. Extended Dwell Catheter/ Midline Catheter, Adults Procedure	3-year review, practice change	Forward to BOD for Approval
6. Witnessing a Patient Signature on Patient's Personal Documents	3-year review	Forward to BOD for Approval
Administrative 200 District Operation		
1. Medical Procedures and Interrogations Requested by Law Enforcement Policy 211	3-year review, practice change	Forward to BOD for Approval
2. Quality Assessment Performance Improvement Plan	2-year review	Forward to BOD for Approval
Food & Nutrition		
1. Nutrition Assessment and Care for Adult Geriatric Patients Policy	3-year review, practice change	Forward to BOD for Approval
2. Nutrition Assessment and Care of High Risk OB Patients Policy	RETIRE	Forward to BOD for Approval
3. Nutrition Care and Assessment for Infants, Pediatrics, & Adolescents Policy	3-year review, practice change	Forward to BOD for Approval
Infection Control		
1. Hand Hygiene	3-year review	Forward to BOD for Approval
2. Infection Prevention Program Plan	1-year review	Forward to BOD for Approval
3. Meningococcal Exposure IC 6.2	3-year review, practice change	Forward to BOD for Approval
4. Standard and Transmission-Based Precautions	3-year review, practice change	Forward to BOD for Approval
Mammography Women's Center		
1. Communication of Results Women Center	Practice change	Forward to BOD for Approval
2. Completion of Diagnostic Report	3-year review, practice change	Forward to BOD for Approval
3. Diagnostic Mammography Policy	3-year review	Forward to BOD for Approval



ADMINISTRATION CONSENT AGENDA

February 18, 2026

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
4. Mammography Image/Data Retention, Check-Out and Copying	3-year review	Forward to BOD for Approval
5. Mammography QA Plan DIT Policy	3-year review	Forward to BOD for Approval
6. Screening Mammography Policy	3-year review, practice change	Forward to BOD for Approval
Medical Staff		
1. Emergency Department Call: Duties of the On-Call Physician 8710-520	3-year review, practice change	Forward to BOD for Approval
Pharmacy		
1. Drug Product Procurement and Inventory Management Policy	3-year review, practice change	Forward to BOD for Approval
2. Hours of Operation and Authorized Access to the Pharmacy	3-year review	Forward to BOD for Approval
Pulmonary Rehab		
1. Patient Enrollment	3-year review	Forward to BOD for Approval
2. Patient Referral	3-year review	Forward to BOD for Approval
Radiology		
1. Radiologists Coverage Non IR #125	3-year review, practice change	Forward to BOD for Approval
Rehabilitation		
1. Community Out-Reach Groups	3-year review, practice change	Forward to BOD for Approval
2. Discharge Criteria	3-year review, practice change	Forward to BOD for Approval
3. Documentation of Progress Note and Discharge Summary	3-year review	Forward to BOD for Approval
4. Home Evaluation	3-year review, practice change	Forward to BOD for Approval
5. Occupational Therapy Assistant Supervision	3-year review, practice change	Forward to BOD for Approval
6. Occupational Therapy Policy	3-year review, practice change	Forward to BOD for Approval
7. Outpatient Medical Records	3-year review, practice change	Forward to BOD for Approval
8. Physical Therapy Assistant Supervision	3-year review, practice change	Forward to BOD for Approval
9. Physical Therapy Policy	3-year review, practice change	Forward to BOD for Approval



ADMINISTRATION CONSENT AGENDA

February 18, 2026

CONTACT: Donald Dawkins, CNE

Policies and Procedures	Reason	Recommendations
10. Referrals for Rehabilitation Services	3-year review, practice change	Forward to BOD for Approval
11. Scope of Services	3-year review, practice change	Forward to BOD for Approval
12. Supervision of Patient, Outpatient Policy	3-year review	Forward to BOD for Approval
13. Supervision Requirements of Minors During Outpatient Rehabilitation	3-year review	Forward to BOD for Approval
14. Therapeutic Recreation Department Policy	3-year review, practice change	Forward to BOD for Approval
Rehabilitation Center		
1. Ethical Code of Conduct	3-year review	Forward to BOD for Approval
2. Interdisciplinary Plan of Care	3-year review, practice change	Forward to BOD for Approval
3. Interdisciplinary Team Conference	3-year review, practice change	Forward to BOD for Approval
4. Mission Statement, Goals and Objectives	3-year review, practice change	Forward to BOD for Approval
5. Patient/Family Conferences	3-year review, practice change	Forward to BOD for Approval
6. Policies and Procedures	3-year review	Forward to BOD for Approval
7. Pre-Admission Screening	3-year review, practice change	Forward to BOD for Approval
8. Provision of Services Not Provided by Tri-City Rehabilitation Center	3-year review, practice change	Forward to BOD for Approval
9. Utilization Review Plan	3-year review, practice change	Forward to BOD for Approval
Staffing		
1. Registry Badge Process Policy	3-year review, practice change	Forward to BOD for Approval
Telemetry		
1. Monitoring Telemetry Patients Using the DASH 3000	3-year review, practice change	Forward to BOD for Approval
2. Scope of Service	3-year review, practice change	Forward to BOD for Approval
3. Weighing Telemetry Patients	3-year review, practice change	Forward to BOD for Approval
Ultrasound & Vascular Imaging		
1. How to Report a Critical/ Stat Read	3-year review, practice change	Forward to BOD for Approval

PATIENT CARE SERVICES

ISSUE DATE: 01/23 **SUBJECT:** Automatic External Defibrillator Checks, Philips

REVISION DATE: 01/23

Patient Care Services Content Expert Approval: ~~11/22~~10/25
Clinical Policies & Procedures Committee Approval: ~~11/22~~12/25
Nursing Leadership Approval: ~~01/23~~01/26
Medical Staff Department/Division Approval: n/a
Pharmacy & Therapeutics Committee: n/a
Medical Executive Committee Approval: n/a
Administration Approval: ~~01/23~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 01/23

A. POLICY:

1. The Automatic External Defibrillator (AED) shall be checked daily by a licensed healthcare provider or designee trained to perform visual checks.
2. AEDs shall be stored in designated locations.
3. Verification of the AED checks will be documented by date and signatures on the AED Checklist.
 - a. A licensed healthcare provider or designee will write "Closed" on the checklist to identify the dates when the department is closed.
4. AED on a closed department do not require checking until the unit is re-opened.
5. AED routine maintenance visual checks shall be completed daily.
6. Daily manual checks are not required as long as the Ready indicator light is green and blinking e.g., flashing.
 - a. The Ready Indicator Light is located above the On/Off button.
 - i. The color and presence of the Ready indicator light is defined as follows:
 - 1) Green blinking light indicates the daily automatic self-test is completed
 - 2) Solid green light (the light is not blinking) indicates the automatic self-test is in progress
 - 3) Ready light off and emitting a series of single chirps and the i-button (information button) is flashing – a self-test error occurs. Press the i-button for instructions.
 - 4) Ready light off and the AED is not chirping and the i-button is not flashing – check the battery. Contact Biomedical Engineering (Biomed) for a replacement battery.
 - 5) Ready light off and there are a series of triple chirps, contact Biomedical Engineering (Biomed).
 - 6) Ready light off and there are no chirps – contact Biomed.
7. The AED automatic daily self-test checks the following:
 - a. Battery
 - b. Connected SMART Pads
 - c. Internal circuitry
8. If the AED needs to be used during a self-test, turn the AED off by pressing the ON/OFF button to stop the test. Then press the ON/OFF button to turn the AED on to use.

B. PROCEDURE:

1. Daily Visual Checks
 - a. Check the Ready Indicator Light
 - i. Ensure the light is green and blinking
 - ii. Check the expiration date on the SMART Pads **or equivalent**. Discard expired SMART Pads replace the pads immediately.
 - iii. Ensure the SMART Pads case is closed
 - 1) If the SMART Pads case is open, the AED assumes that it is being used and will not run the self-test
 - iv. Ensure a set of pads are connected to the defibrillator
 - 1) The SMART Pads must be connected to the AED in order for the automatic self-test to be performed.
 - 2) When the defibrillator pads are not connected to the defibrillator, the defibrillator will start chirping and the i-button located on the front of the defibrillator will start flashing
 - b. Ensure two (2) packs of SMART Pads **or equivalent** (appropriate for department patient type) are in the AED carrying case (except for neonatal care units)
 - c. Check battery expiration date. Contact Biomed to replace expired battery.
 - d. Document the checks on the AED Checklist.
2. AED Battery Insertion Checks
 - a. Battery insertion self-test should only be performed when the AED:
 - i. Is first put into service
 - ii. Each time the defibrillator is used to treat a patient
 - iii. Battery is replaced
 - iv. AED may have been damaged
3. Manual AED checks may be performed any time by removing the battery for 5 seconds then reinstalling the battery. The test will take one minute.

C. **FORM(S):**

1. Tri-City Medical Center Automatic External Defibrillator (AED) Checklist

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

1. Patient Care Services (PCS) Policy: Rapid Response Team

E. **REFERENCE(S):**

1. Philips Medical System. (2019). Heartstart FRx Defibrillator Owner's Manual. 861304, Edition 14.
2. Phillips Medical System (2021, Sept). Phillips HeartStart AED: HeartStart trx AED Demo.



HEARTSTART FRx AED Daily Visual Checks

Daily Visual Checks

Instructions: Check AED once a day. Document Visual Checks completed on the AED Checklist per policy.

1. Check the Ready Light Indicator – light should be Green and blinking (flashing)
2. If the Green indicator light is not blinking, this indicates the daily automatic self-test is in progress.
 - a. Wait 1 -2 minutes to allow the AED to complete the daily check.
3. Check expiration date on SMART Pads
 - a. Discard and replace expired pads
4. Ensure the SMART Pads case is closed
5. Ensure a set of SMART Pads are connected to the defibrillator
6. Ensure one extra pack of SMART Pads are in the AED
 - a. Ensure package is seal. Replace damage or opened package.
7. Check battery expiration date. If batteries are expired contact Biomed.
 - a. Do not remove battery for daily visual checks.
8. Document the date and your signature on the AED checklist.

Troubleshooting points

1. Ready light is off and emitting a series of single chirps and the i-button (information button) is flashing – a self-test error occurred. Press the i-button for instructions.
2. Contact Biomed for the following:
 - a. Ready Light is Off and the AED is not chirping and the i-button is not flashing – check battery.
 - i. Contact Biomed to obtain a replacement battery.
 - b. Ready Light is ON and there are a series of triple chirps.
 - c. Ready Light is OFF and there are no chirps

References:

- Philips Automatic External Defibrillator Checks.
- Phillips Heartstart FRx Defibrillator Owners' Manual 861304 Edition 14

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CANDIDA AURIS SCREENING

I. POLICY:

- A. Function: To describe the process for screening patients for *Candida auris*.
- B. Circumstances:
 - 1. Setting: Tri-City Medical Center (TCMC)
 - 2. Supervision: No supervision is required and the Registered Nurse (RN) may initiate this standardized procedure independently.
 - 3. Patient contraindications:
 - a. If the patient has a documented history of *Candida auris* colonization, they are considered lifelong carriers and repeat skin sampling is not required or recommended
 - 4. The following patient populations admitted to Tri-City ~~Medical Center Healthcare District (TCMCHD)~~ shall be screened for *Candida auris* colonization ~~during pre-registration process or~~ within 24 hours of admission:
 - a. The patient has directly transferred from any Long-Term Acute Care Hospital (LTAC), Sub-Acute ventilator unit or Skilled Nursing Facility (SNF)
 - b. Patients ~~not included above~~ with other known risk factors ~~such as patients:~~
 - i. Admitted with a trach in place or mechanically ventilated
 - ii. History of positive Carbapenem resistant organism (CRO), ~~and~~
 - iii. With overnight hospitalizations or invasive procedure outside of the U.S in the past 12 months
 - iv. The patient is receiving dialysis
 - 5. ~~Transmission based contact precautions may never be discontinued for a known *C. auris* carrier~~

II. PROCEDURE FOR COLLECTING THE SWAB:

- A. Place the patient on Contact Precautions upon admission while awaiting test results
- B. Procedure for collecting the swab:
 - 1. Place order for Fungal Culture and include “screening for *Candida auris*” in the comments. Under body site, select axilla and groin
 - 2. Before beginning, perform hand hygiene and wear appropriate PPE for Contact Precautions
 - 4.3. Using one culture swab, firmly rub the swab across the indicated site 3-5 times.
 - a. Single swab axilla and groin composite collection method:
 - i. Rub both sides of the swab over the left axilla skin surface and then the right, targeting the crease in the skin where the arm meets the body
 - ii. With the same swab used on the axilla, rub both sides of the swab over the left groin, then repeat on the right groin
 - iii. Return the swab to the collection tube and return to lab

III. DOCUMENTATION:

- A. When implementing orders from a standardized procedure, the RN shall enter the order into the electronic health record, unless the screening process triggers the order

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Practice Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/25	05/25	07/25	07/25	n/a	10/25	01/26	02/26	n/a	

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

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

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

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

- A. All **Registered Nurses (RNs)** Healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform Candida auris screening Standardized Procedure.

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

- A. Management of Patients with multidrug resistant organism (MDRO) and/or *C. difficile* Infection for additional information.

VIII. **REFERENCE(S):**

1. <https://www.cdc.gov/candida-auris/hcp/index.html>
2. https://www.cdc.gov/candida-auris/about/?CDC_AAref_Val=https://www.cdc.gov/fungal/candida-auris/index.html
3. <https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/MDROCoorting.pdf>
4. [file:///C:/Users/rlmoore/Downloads/CAHAN_Cauris_Surveillance_NorCal_Feb2023%20\(1\).pdf](file:///C:/Users/rlmoore/Downloads/CAHAN_Cauris_Surveillance_NorCal_Feb2023%20(1).pdf)
5. https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/cahan/communications_documents/3-22-24.pdf
6. Admission Screening for *C. auris* in Acute Care Hospitals in CA
https://www.cdph.ca.gov/Programs/CHCQ/HAI/CDPH%20Document%20Library/C_auris_AdmissionScreening_in_CA_ACHs_webinar_012324.pdf

PATIENT CARE SERVICES

ISSUE DATE: 11/11 **SUBJECT:** Chemotherapy Prescribing,
Processing and Preparation

REVISION DATE: 05/13, 06/14, 07/15, 09/16, 09/19,
08/23

Patient Care Services Content Expert Approval:	10/2208/2401/25
Clinical Policies & Procedures Committee Approval:	11/2208/2402/25
Nursing Leadership Approval:	01/2309/2403/25
Division of Oncology Approval:	03/2311/2411/25
Pharmacy & Therapeutics Committee Approval:	05/2312/25
Medical Executive Committee Approval:	06/2301/26
Administration Approval:	08/2302/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/23

A. PURPOSE:

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

B. CHEMOTHERAPY PRESCRIBING PROCEDURE:

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

- b. Date the order is written
- c. Diagnosis
- d. Regimen name or protocol name
- e. Cycle number and day, when applicable
- f. Written using the generic name of the agent
 - i. Free of any number prefixes such as “5-fluorouracil”, which could be misinterpreted as part of the order dose or schedule requirements
- g. Doses may not include trailing zeros; a leading zero (0) must be used for doses less than one (1) mg
- h. The dose calculation consisting of:
 - i. The calculation methodology
 - 1) Doses will use the metric system and include dose/m², dose/kilogram or Area Under Curve (AUC) when appropriate. The actual calculated dose will be included
 - 2) Doses will be written as the amount per dose per day (e.g. cisplatin 20 mg/m² daily x 5 days, or cytarabine 3000 mg/m²/dose every 12 hours on days 1,3, and 5)
 - 3) For carboplatin calculated with the Calvert equation:
 - a) Target AUC
 - b) Creatinine Clearance and equation used to calculate if different than Cockcroft-Gault
 - c) Serum Creatinine used if different than current lab
 - d) Actual, ideal or adjusted weight used to calculate dose
 - ii. Variables used for calculation methodology including height and weight
 - iii. The frequency at which these variables are to be measured
 - 1) In the absence of parameters for frequency of remeasurement for height and weight, the following will be used:
 - a) Inpatient chemotherapy: weight shall be measured within 48 hours from the start of the new cycle. Height should be measured with each new hospital admission.
 - b) Outpatient chemotherapy: weight shall be measured at the beginning of each new cycle. Height should be measured at the beginning of each new regimen.
 - iv. The changes in values that prompt confirmation of dosing
 - 1) In the absence of parameters for changes in dose based on weight and height, the following shall be used:
 - a) **Dose confirmation is required if the calculated dose, based on the patient’s current height and weight, deviates by more than 10% from the treatment plan dose.**
 - b) ~~Cytotoxic chemotherapy: the difference of the calculated dose based on the current height and weight is greater than 5% of treatment plan dose.~~
 - c) ~~Monoclonal antibodies: the difference of the calculated dose based on the current height and weight is greater than 10% of treatment plan dose.~~
- i. Date of administration
- j. Route of administration
- k. Allergies
- l. Supportive care treatments appropriate for the regimen (including premedications, hydration, growth factors and hypersensitivity medications)
- m. Parameters that would require holding or monitoring the dose, for example, laboratory values, diagnostic test results and patient’s clinical status

- i. In the absence of treatment parameters, the lab values of ANC \leq 1500cells/ μ L, platelets \leq 100,000/uL total bilirubin \geq 1.4 mg/dL, CrCl $<$ 60 mg/dL (if drug renally cleared) and any other laboratory values specific to prescribed chemotherapy that are not within normal limits will be approved by physician before preparation of dose.
 - ii. Guidelines for timing of labs:
 - 1) In chemotherapy naïve patients (no prior chemo) lab results should be no older than seven (7) days.
 - 2) For patients currently receiving chemo with the following frequencies:
 - a) Every seven (7) days – lab results should be within two (2) calendar days
 - b) Every fourteen (14) days and beyond – lab results can be within three (3) calendar days (i.e. 72 hours)
 - 3) Daily (consecutive days of chemo) – labs should be drawn on day one (1).
 - 4) Labs drawn with alternative timing may be accepted at the pharmacists' discretion.
 - iii. Cumulative dose for medications with dose ceilings including daunorubicin, doxorubicin, doxorubicin liposomal, epirubicin, bleomycin, mitomycin C will be calculated and included on the order.
 - n. Sequence of drug administration, when applicable
 - o. Rate of drug administration, when applicable
 - p. An explanation of time limitation, such as the number of doses for which the order is valid.
6. Exceptions
- a. Physicians that are without chemotherapy privileges may write for chemotherapy only if they have been granted privileges by the medical staff to do so as related to their specialty including but not limited to:
 - i. Ectopic pregnancy
 - ii. Rheumatoid arthritis
 - iii. Systemic lupus erythematosus
 - iv. Certain dermatologic conditions
 - v. Certain ophthalmic procedures
 - vi. Other auto-immune conditions as identified in the literature
 - vii. Androgen deprivation therapy for prostate cancer
 - b. All orders must be written on a standard TCHD Chemotherapy Order Form and subject to all other requirements stated above.
 - i. Use of standard pre-printed form is not required only if:
 - 1) Oral agent is prescribed for a non-oncologic condition and may be ordered via computerized provider order entry (CPOE).
 - 2) Androgen deprivation therapy is prescribed by an urologist or oncologist for prostate cancer.
 - 3) Intramuscular (IM) methotrexate is ordered for ectopic pregnancy via CPOE
 - ii. Outpatient oral chemotherapy may be continued in-house by an attending physician via CPOE. Pharmacist shall verify that patient is currently on oral chemotherapy regimen.
 - c. Non-systemic chemotherapy such as intrathecal, intravesical or directly into an organ (i.e. chemoembolization) may be ordered and administered by a qualified physician in other areas of the hospital (interventional radiology, operating room). Use of standard TCHD Chemotherapy Order Form is not required.

C. **CHEMOTHERAPY PROCESSING PROCEDURE:**

1. Pharmacist verification for new chemotherapy regimens:
 - a. Two independent pharmacist checks will be performed to ensure the order follows the Chemotherapy Prescribing Procedure prior to the initiation of a new chemotherapy regimen.
2. Two pharmacists working independently verifies the following prior to each dose dispensation:
 - a. Two patient identifiers
 - b. Drug name
 - c. Drug dose
 - d. Route of administration
 - e. The calculation for dosing, including the variables used in this calculation
 - f. Treatment cycle and day of cycle
 - g. The correct time has elapsed between treatments.
 - h. Weight and labs are within range and dose adjustments are confirmed with oncologist.
 - i. Allergy, drug sensitivity, adverse drug effect histories and current medication profile should be evaluated for potential drug interactions with planned chemotherapy treatment.
 - j. Concentration of drug in IV solution is within acceptable concentration range.
 - k. Drug and solution are compatible.
 - l. Correct bag, tubing and filter have been selected.
 - m. Chemotherapy orders have not changed after the initial two pharmacist new chemotherapy regimen check performed prior to cycle one.
 - i. If regimen has been modified or changed, two pharmacists must recheck that the order is prescribed according to policy.
 - n. All electronic order entries match paper order sets.
3. All checks will be documented electronically or on a chemotherapy worksheet.
4. The verification process must be followed completely before any dose can be prepared.
 - a. Exception: For TCHD OIC, the second pharmacist verification ~~can be omitted~~ **may be performed by a Chemotherapy Certified Registered Nurse (RN)Registered Oncology Nurse.**

D. CHEMOTHERAPY PREPARATION AND DISPENSING:

1. Chemotherapy is prepared by a licensed pharmacy technician or pharmacist.
2. If an oral chemotherapy or other hazardous drug is to be physically manipulated or repackaged, the process must be done in a biological safety cabinet (vertical flow hood) to prevent inhalation exposure.
 - a. The hood must be cleaned according to policy and procedure prior to sterile compounding.
3. All intravenous hazardous chemotherapy will be prepared using a Closed System Transfer Device (CSTD), if compatible, in a Biological Safety Cabinet using Hazardous Drug Preparation guidelines.
4. All parenteral hazardous chemotherapy medications will be spiked and primed in the chemo hood if dispensed as IV piggyback.
5. The syringes for each drug and/or solution used in preparing the product (including syringes used to dilute drug vials) must be checked by the pharmacist before injecting into IV solution.
 - a. The syringe pullback method is not to be used for chemotherapy final volumes.
6. All intrathecal doses:
 - a. Shall not be prepared during preparation of any other agents
 - b. Are labeled with an identifiable intrathecal medication label
 - c. Must be placed in a separate transport bag
 - d. Shall be delivered only with other medications intended for administration intrathecally
7. Maximum syringe size dispensed should be 35 mL

- a. Any IV push dose in a syringe should be less than three quarters full to minimize the risk of chemo spill.
8. An overfill volume of 0.05 mL will be added to all subcutaneous doses
9. Two pharmacists, working independently must verify the following:
 - a. The drug vial(s)
 - b. Concentration
 - c. Drug volume or weight
 - d. Diluent type and volume, when reconstituted
 - e. Administration fluid type, volume and tubing
 - f. Final appearance and integrity of drug and container
 - g. Type of final container (e.g. syringe/and or minibag type) are appropriate for the specific chemotherapy.
 - h. Expiration date and times
 - i. Exception: For TCHD OIC, the second pharmacist verification can be omitted.
10. Upon completing the chemotherapy preparation process, the final product shall be labeled immediately upon preparation
 - a. Labels include the following elements, at a minimum:
 - i. Patient's full name and second patient identifier (i.e. date of birth or medical record number)
 - ii. Full generic drug name
 - iii. Drug dose
 - iv. Drug administration route
 - v. Rate of administration
 - vi. Total volume required to administer the drug
 - vii. Date the medication is to be administered
 - viii. Expiration or beyond use date and time
 - ix. Sequencing of drug administration, when applicable, and total number of products and individual products sequence within that total grouping when medication is provided in divided doses
 - x. Special handling instructions and caution statements (i.e. intrathecal use only)
 - xi. Final concentration of product on syringe labels (i.e. doxorubicin 50mg/ 25mL)
 - xii. All minibag or large volume parenterals include volume of each component as well as a total volume.
11. All hazardous chemotherapeutic agents regardless of route and indication shall be dispensed from the pharmacy with an auxiliary Chemotherapy Warning label
12. Any IV line that has been primed with active drug will be dispensed from the pharmacy with appropriate auxiliary label
13. All chemotherapy doses are placed in a sealable chemotherapy bag
14. Chemotherapy must be put into a chemotherapy cooler containing a spill kit for transportation out of pharmacy.
15. Chemotherapy will only be delivered to designated oncology floors.

E. **FORM(S):**

1. Chemotherapy Orders 8711-3222 Form - Sample

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

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

G. **REFERENCE(S):**

1. NeussSiegel RD, LeFebvre KB, Temin S, M-N; et al. **Antineoplastic Therapy Administration Safety Standards for Adult and Pediatric Oncology: ASCO-ONS Standards.** *JCO Oncol Pract* 0, OP.24.00216 DOI:[10.1200/OP.24.00216](https://doi.org/10.1200/OP.24.00216). (2016) 2016

~~Updated American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards, Including Standards for Pediatric Oncology. *Journal of Oncology Practice*.~~

2. Goldspiel B, Hoffman JM, Griffith NL, et al. ASHP Guidelines on Preventing Medication Errors With Chemotherapy and Biotherapy. *Am J Health-Syst Pharm*. 2015; 72:e6-35.
3. **Fahrenbruch, R. Dose Rounding of Biologic and Cytotoxic Anticancer Agents: A Position Statement of the Hematology/Oncology Pharmacy Association. *Journal of Oncology Practice*. 2018; Vol 14, 3.**

PATIENT CARE SERVICES

ISSUE DATE: 11/94 **SUBJECT:** Consent for Operative or Other Procedures

REVISION DATE: 09/95, 11/96, 10/97, 07/99, 06/03
01/06, 02/06, 02/07, 04/09, 12/10,
01/16, 08/22

Patient Care Services Content Expert Approval: ~~06/2006/25~~
Clinical Policies and Procedures Approval: ~~02/2210/25~~
Nursing Leadership Approval: ~~03/2211/25~~
Operating Room Committee Approval: ~~04/2212/25~~
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: ~~07/2201/26~~
Administration Approval: ~~08/2202/26~~
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 08/22

A. PURPOSE:

1. To comply with legal and regulatory standards by defining Tri-City Healthcare District's (TCHD) process to obtain a valid consent, from an adult patient prior to diagnostic or therapeutic invasive procedures.

B. DEFINITION(S):

1. Adult:
 - a. An individual who has reached the age of eighteen (18) years, or a minor who has entered a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the United States of America, or who has been declared emancipated pursuant to Family Code § 7122 et seq. (Family Code, § 7002), or self-sufficient minor (fifteen [15] years or older, living apart from his/her parents, and manages his/her own financial affairs) pursuant to Family Code § 6922. An emancipated minor may consent to medical, surgical, psychiatric, or hospital care without parental consent or knowledge. [Family Code §7050 (e)(1)]
2. Consent Form:
 - a. A document that verifies a patient has been informed of a pending diagnostic or therapeutic invasive procedure; understands the information and has given consent to the physician/Allied Health Professional (AHP).
 - b. Informed consent should be obtained prior to the consent form being signed.
 - c. The signed consent form is to be obtained and kept in the patient's record.
3. Informed Consent:
 - a. Voluntary consent given by a person or a responsible proxy (e.g., legal guardian, responsible party) for invasive diagnostic or therapeutic procedure after being informed of:
 - i. The purpose, methods, benefits, and risks.
 - ii. The likelihood of the patient achieving their goals.
 - iii. Any potential problems that might occur during recuperation.
 - iv. Reasonable alternatives to the patient's proposed care, treatment, and services.
 - v. Side effects related to alternatives.
 - vi. Risks related to not receiving the proposed care, treatment or services.

- b. It is the responsibility of a physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. The disclosure of any material information and obtaining informed consent shall be the responsibility of the physician.
 - c. Informed consent must include a verbal explanation by a physician of the patient's right to refuse or accept medical treatment.
 - d. No medical treatment may be administered to a patient without informed consent except in an emergency situation or circumstances otherwise authorized by law.
 - e. The patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time. Licensed mental health professionals or licensed nursing staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure.
 - f. The essential criteria of informed consent are:
 - i. The subject has both knowledge and comprehension.
 - ii. Consent is freely given without duress or undue influence.
 - iii. The right of withdrawal at any time is clearly communicated to the subject and documented by the physician/AHP in the patient's medical record.
4. Emergency:
- a. A situation in which immediate services are required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required to prevent serious disability or death.
5. Minor:
- a. For minors see Patient Care Services Policy: Consent for Minors.
6. Procedures/Treatments Requiring Informed Consent/Consent forms:
- a. Informed consent and a consent form are required for any procedure or medical treatment that is considered complex and involve risks that are not commonly understood. The final determination of the "complexity" of the procedure/treatment is the responsibility of the physician/AHP, in accordance with the criteria listed below:
 - i. Any procedure that requires pre-medication for sedation/analgesia.
 - ii. Any invasive procedure which involve incision, percutaneous puncture or insertion, and requires the services of the Endoscopy Lab, Operating Room, Cardiac Catheterization Laboratory, or Interventional Radiology.
 - iii. **For sensitive or invasive exams (e.g., pelvic, breast, prostate, rectal) performed on anesthetized patients outside of medically necessary procedures, especially for educational purposes.**
 - iv. As required by law including, but not limited to:
 - 1) Blood Transfusion
 - 2) Human Immunodeficiency Virus (HIV) Blood Tests
 - 3) Investigational Drugs or Devices
 - 4) Human Experimentation
 - 5) Treatment for Breast or Prostate Cancer
 - 6) Use of Psychotropic Medications
 - 7) Electroconvulsive Therapy

C. **PROCEDURE:**

- 1. A signed consent form is required prior to invasive diagnostic or therapeutic procedures.
 - a. After the physician/AHP has obtained the patient's informed consent, a consent form for a procedure must be signed by the patient.
 - b. The completed Consent for Operative or Other Procedures shall be placed on the patient's chart under Operative/Consents.
 - c. A copy of the signed form shall be given to the patient/legal representative.
 - d. Exception: Treatment may be initiated without informed consent if there is

documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.

2. Consent must include:
 - a. Nature of the proposed care, treatment, services, medications, interventions, or procedures.
 - b. Potential benefits, risks, or side effects of the procedure including potential problems that may occur during recuperation.
 - c. Likelihood of achieving care, treatment, and/or service goals.
 - d. Reasonable alternatives.
 - e. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, or service.
 - f. Limitations of the confidentiality of information learned from or about the patient as indicated.
 - g. Any independent medical research or significant economic interests the physician/AHP may have related to the performance of the proposed operation/procedure.
3. The consent form must be signed prior to the administration of narcotics or mind-altering drugs.
 - a. The physician/AHP must determine if the patient is competent to sign the consent or if the procedure must be delayed if the consent is not obtained before the administration of narcotics or mind-altering medications.
 - i. The decision to continue with the procedure must be documented by the physician/AHP in the medical record.
4. If, in the opinion of the physician/AHP, the patient is permanently or temporarily incapable of giving consent, consent is obtained from one of the following, in the order listed:
 - a. Surrogate decision maker who has been verbally designated to the physician/AHP who has undertaken primary responsibility for the patient. **The surrogate may be chosen from any of the following persons:**
 - i. **The patient's spouse or domestic partner.**
 - ii. **An adult child of the patient.**
 - iii. **A parent of the patient.**
 - iv. **An adult sibling of the patient.**
 - v. **An adult grandchild of the patient.**
 - vi. **An adult relative or close personal friend.**
 - a.b. This verbal designation must be documented in the medical record and is valid:
 - i. During the duration of the hospitalization,
 - ii. The course of illness, or
 - iii. Sixty (60) days, whichever is shorter.
 - ~~b.c.~~ Agent identified in an advanced directive.
 - ~~c.d.~~ When both an agent and surrogate are appointed by the patient, the surrogate takes precedence over the agent for the limited duration previously stated.
 - ~~d.e.~~ Conservator, who has been authorized by the court to make health care decisions or guardian.
 - ~~e.f.~~ Court appointed surrogate decision maker or court order if none of the above exist.
 - ~~f.g.~~ Closest available relative, when appropriate, to rely on the consent of this person (the person has capacity, trustworthy motives, likely that patient would consent if able, and no objections from close relatives). The physician/AHP should determine appropriateness for procedures requiring informed consent.
 - ~~g.h.~~ A registered domestic partner has the same authority to make a health care decision for their incapacitated domestic partner as a spouse would have to make a healthcare decision for their incapacitated spouse.

- iii. The medical interpreter identification/number.
 - d. If the consent form is not available in the patient's or patient representative's primary language, the interpreter shall verbally translate the form and ask the patient to sign the English form if the patient or the patient's representative agrees to the terms and conditions.
9. State and Federal regulation mandate special informed consent requirements for reproductive sterilization, is primarily for the purpose of rendering the person incapable of reproducing ("elective sterilization"), and elective sterilization may be performed only when the following conditions are met:
 - a. Informed consent has been obtained from the patient.
 - b. The patient shall be able to understand the content and nature of the informed consent process.
 - c. The patient shall not be in a condition or mental state in which judgment is significantly altered.
 - d. The patient shall not be in labor, or less than twenty-four (24) hours postpartum or post abortion.
 - e. The patient shall not be seeking to obtain or obtaining an abortion.
 - f. Medi-Cal or Federally funded patient shall have the following additional requirements:
 - i. Patient shall be twenty-one (21) years of age or older.
 - ii. Patient shall not have been declared mentally incompetent by a court of competent jurisdiction, unless a limited conservator has been appointed and specific criteria have been met.
 - iii. The patient shall not be involuntarily confined or detained in a correctional or rehabilitative facility, or confined, under a voluntary commitment in a facility for the care and treatment of mental illness.
 - g. The sterilization consent has been signed by the necessary parties and is available on the chart prior to procedure.
 - h. The required waiting period has been satisfied.
 - i. Thirty (30) days, but not more than 180 days, shall pass after the appropriate sterilization consent was signed by patient or conservator.
 - ii. Elective sterilization shall be performed less than thirty (30) days after the patient has signed the consent form only in the following circumstances:
 - 1) Private (pay status) patient voluntarily requests in writing that the thirty (30) day waiting period be waived to no less than 72 hours.
 - 2) The elective sterilization is performed at the time of emergency abdominal surgery or at the time of a premature delivery, and the physician/AHP certifies that informed consent was given and the sterilization consent form was signed at least thirty (30) days before the intended date of sterilization and that at least 72 hours have actually passed since consent was given and the form was signed, and the physician/AHPs describes the nature of the emergency, or indicates the prior expected delivery date on the sterilization consent form.
10. State regulations mandate special requirements for physician/AHPs regarding informed consent for hysterectomies.
 - a. The Authorization for and Consent to Hysterectomy shall be used to document these requirements.
 - i. The Hysterectomy Consent form is needed in addition to the Consent for Operative or Other Procedures form.
 - b. These regulations outline specific requirements for physician/AHPs that must be documented in the medical record, including that the physician/AHP must obtain "verbal and written" consent prior to the performance of the hysterectomy.
 - c. The informed consent procedure by the physician/AHP, shall provide that at least all of the following information is given to the patient verbally and in writing:

- i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.
 - ii. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.
 - iii. Advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result if the patient is not already sterile or postmenopausal.
 - iv. A description of the discomforts and risks that may accompany or follow the performance of the procedure.
 - v. A description of the benefits or advantages that may be expected as a result of the hysterectomy.
 - vi. Approximate length of stay in the hospital.
 - vii. Approximate length of time for recovery.
 - viii. Financial cost to the patient of the physician/AHP's and surgeon's fees.
11. A signed consent form is in effect until the patient changes his/her mind, or the physician/AHP alters the nature of the procedure (in which case a new consent is required).
12. Consent for a medical emergency:
 - a. Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able or if a qualified legal representative were present, the consent would be given. The exception applies to minors as well as to adult patients.
CHA 2019.
 - b. The physician/AHP must document the determination of the medical necessity in the medical record.
 - c. The physician/AHP does not sign the consent on behalf of the patient.
 - i. The unsigned consent is maintained in the medical record.
 - ii. TCHD personnel shall document on the consent "See progress notes dated for physician/AHP documentation of medical emergency indicating need to proceed with procedure."
13. Telephone/Facsimile/Email Consent:
 - a. Informed consent may be obtained by telephone, facsimile, or email when the person having the legal capability to consent for the patient is not otherwise available.
 - i. TCHD staff must make a reasonable effort to validate the person is authorized to give consent.
 - b. When a telephone is used, the responsible physician/AHP must provide the patient's legal representative with the same information as would be presented to the individual in person.
 - c. Two (2) individuals (either two [2] TCHD staff personnel or the physician/AHP and one [1] TCHD staff member) must witness the consent conversation.
 - i. The patient's legal representative must be informed the conversation is being witnessed.
 - ii. The person(s) witnessing the conversation must sign and date documentation of the conversation on the Telephone Consent Form.
 - iii. The Telephone Consent Form with the signature of the two (2) witnesses, is placed in the medical record.
 - d. Physician/AHP instructions may be emailed to the legal representative.
 - i. In cases of electronically transmitted consent, the following occurs:
 - 1) Specific instructions regarding where the consent will be emailed shall be provided by the person who is legally able to consent for the patient.

- 2) Written confirmation proceeding the procedure and documentation of the patient's name, secured to the cover sheet if applicable, are maintained in the medical record.
- e. In cases of facsimile consent:
 - i. Direct discussion with the legal representative giving consent must first occur.
 - ii. The legal representative may fax the consent after receiving full information regarding the procedure.
 - iii. The facsimile document(s), along with the cover sheet, is placed in the health record.
 - 1) Request the legal representative to send the original signed document to TCHD. This document is filed in the patient's medical record upon receipt.
14. Consent for an incompetent patient:
 - a. If a patient is incompetent or otherwise unable to give informed consent and does not have a conservator or holder of a durable power of attorney for healthcare decisions, the physician/AHP may proceed by obtaining consent of the closest available relative.
 - b. The physician/AHP must document in the medical record that there is no known conservator or durable power of attorney for healthcare and that the procedure is necessary.
 - c. If there is no relative available, and if the procedure is not an emergency, ~~the Director of~~ Risk Management as well as in house counsel, are contacted to assist per Administrative Policy: Decision Making for Unrepresented Patients.

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

1. Administrative Policy: Decision Making for Unrepresented Patients 397
2. Patient Care Services Policy: Communication with the Sensory Impaired and/or Persons with Language Barriers
3. Patient Care Services Policy: Consent for Minors

E. **REFERENCE(S):**

1. 9 CCR § 784.29.
2. California Code of Regulations (CCR) Title XXII §51305.6 & 70707.5
3. California Hospital Association (2017 24). California Hospital Consent Manual. Sacramento, CA: California Hospital Association, Chapter 3.
4. The Joint Commission (2015). Hospital Accreditation Standards. Illinois: Joint Commission Resources.
5. Consent by Minor, Cal. FAM § 6922 (1992).
6. General Provisions, Cal. FAM § 7002 (1992).
7. Hysterectomies, Cal. HSC §1690 – 1691 (2009).



PROCEDURE: EXTENDED DWELL CATHETER /MIDLINE CATHETER, ADULTS

Purpose: To outline the following nursing responsibilities for patients with or requiring midline catheter placement:

1. Patient selection
2. Placement of catheter
3. Assessment
4. Maintenance
5. Documentation
6. Flushing
7. Blood specimen collection
8. Dressing changes
9. Removal

Supportive Data:

1. Infusion Nursing Standards of Practice
2. AACN Procedure Manual for High Acuity, Progressive and Critical Care
3. Standards of Care for Adults
4. Central Venous Access Procedure
5. Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10)

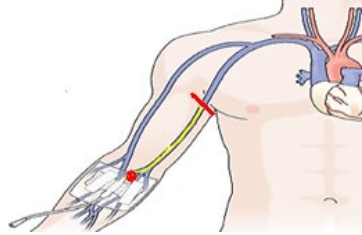
Equipment:

1. Extended Dwell Catheter Insertion Kit (3 French or 4 French)
2. Sterile gloves
3. Microclave (green or yellow as appropriate)
4. Peripheral IV dressing (such as SorbaView SHIELD Contour)
5. Swabcap port protector
6. Central Line Change Kit

A. DEFINITION(S):

1. Extended Dwell Catheter (EDC):
 - a. An EDC is a peripheral intravenous (IV) catheter 2.4 inches in length, power-injectable and approved by the Food and Drug Administration (FDA) for use up to 29 days.
 - b. The most favorable site for EDC insertion is mid-forearm. However, placement can be in any vein deemed appropriate by the inserting Registered Nurse, including hand veins.
 - i. EDC catheters shall not traverse flexion surfaces, such as the wrist or antecubital fossa.
 - ii. An EDC catheter is not a ~~M~~midline, unless inserted above the antecubital fossa and the catheter tip terminates distal to the axillary line.
 - iii. An EDC catheter is not a Peripherally Inserted Central Catheter (PICC).
 - iv. An EDC catheter is not a centrally inserted catheter, i.e. central line.
2. Midline Catheter:
 - a. A ~~M~~midline catheter is an EDC peripheral IV catheter 3.1 to 3.9 inches in length, power-injectable and FDA cleared for use up to 29 days, that is inserted into the upper arm via the deeper basilica, cephalic, or brachial veins, with the internal tip located at or near the level of the axilla and distal to the shoulder. See illustration below.
 - b. Midlines catheters do not extend beyond the axillary line and do not extend into the vena cava; see illustration below.
 - i. A midline catheter is not a PICC.
 - ii. A ~~M~~midline catheter is not a centrally inserted catheter, i.e. central line.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Infection Control Committee	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/17, 07/20, 04/24, 10/25	06/14, 07/17, 08/20, 04/24	06/14, 07/17, 10/20, 06/24	10/20, 10/24	09/14, 10/17, 12/25	09/14, 11/17, 05/21, 02/25	10/14, 11/17, 07/21, 01/26	09/21, 02/26	05/15, 01/18, n/a	05/15, 01/18, 09/21



B. POLICY:

1. In the absence of a clear indication for a central line, an EDC or **M**midline catheter should be considered for all patients requiring access for up to twenty-nine (29) days, as well as difficult access or “hard stick” patients and patients requiring frequent phlebotomy.
2. Contraindications to EDC or **M**midline use: **A**an EDC or **M**midline catheter should not be used for the following indications:
 - a. Continuous vesicant therapy
 - b. Total parenteral nutrition
 - c. Any intravenous medication requiring central venous access for administration
 - d. Patients with known allergy to the components of the EDC
3. EDC and **M**midline catheters may be inserted in the patient’s room by a Physician/Allied Health Professional (AHP) or a Registered Nurse (RN) trained to insert EDC and **M**midline catheters for patients meeting one or more of the following criterion:
 - a. Patient has poor or limited peripheral access.
 - b. Two unsuccessful attempts to insert a peripheral catheter by one RN and a reassessment by a 2nd RN who is also unable to insert a peripheral catheter after two attempts.
 - c. Patient requires minimum of one (1) week to twenty-eight (28) days of intravenous (IV) therapy for hydration solutions, isotonic or near isotonic drugs and solutions, pain medications, antibiotics, blood products, or frequent blood sampling.
4. EDC and **M**midline catheters shall be labeled with an EDC catheter sticker.
5. EDC and **M**midline catheter placement should be avoided in an extremity on the same side that the patient had a mastectomy with axillary node resection, fistula, shunt, or radial artery surgery.

C. PROCEDURE FOR BEDSIDE INSERTION:

1. Verify Physician order for peripheral IV.
2. Verify patient per Patient Care Services: Identification, Patient Policy.
3. Gather equipment.
4. Aseptic or sterile technique shall be used during EDC or **M**midline catheter insertion.
5. Prepare skin at insertion site with 2% chlorhexidine scrub. Allow to dry thoroughly.
6. Insert EDC or **M**midline catheter according to manufacturer’s instructions.
7. Ultrasound guidance may be used, but is not required, for insertion of EDC or **M**midline catheter.
8. Use Biopatch disk or equivalent around insertion site. Cover using sterile dressing.
9. EDC and **M**midline catheters shall be secured using a hospital-approved IV occlusive dressing.
10. Ensure all connections are tight and free from leakage.
11. Unless continuously infusing, place a neutral displacement connector and flush with at least 10 mL preservative-free normal saline.
12. The inserting RN shall document the insertion of the EDC or **M**midline catheter in the Electronic Health Record (EHR), i.e. catheter location, site condition, dressing, date and time of insertion etc.
 - a. If a **M**midline is placed by a physician or PA, the primary RN shall document the insertion in the EHR
13. Ensure EDC or **M**midline catheter is labeled with an EDC catheter sticker.

D. ASSESSMENT:

1. Monitor site and catheter position after insertion for the following:
 - a. Minor bleeding is anticipated within the first 24 hours of insertion.
 - b. If excessive bleeding occurs, do not remove existing dressing as this can dislodge any clot that has begun to form. Instead, apply pressure and consult with the Rapid Response Team.
 - i. Notify the physician or PA for excessive bleeding from a Mmidline.
2. Monitor IV and assess per the Patient Care Services: Standards of Care, Adult.
 - a. Peripheral IV site shall be assessed on admission, ongoing, and transfer from other nursing unit.
3. Document assessment findings in the EHR.

E. CARE AND MAINTENANCE:

1. Assess site every shift, with flushing, prior to and after the administration of medications and PRN.
 - a. Always flush using positive pressure, push/pause technique.
 - b. Flush EDC or Mmidline catheter with at least 10mL of preservative-free normal saline at least every 8-12 hours.
 - c. Assess blood flow before and after administration of medications.
 - d. Flush EDC or Mmidline catheter immediately before and after administration of medications with at least 10 mL preservative-free normal saline.
 - e. Flush EDC or Mmidline catheter after infusing blood products with 20 mL of preservative-free normal saline.
 - f. For saline locked EDC or Mmidline catheters, always clamp tubing after instilling flush solution.
2. Avoid measuring blood pressure, performing venipuncture, or administering injections in the extremity with a Mmidline catheter.
 - a. It is recommended to place a sign at the patient's bedside to alert clinicians to avoid use of the extremity with the Mmidline catheter.
3. Review the Patient Care Services: Standards of Care Adult Procedure- Infusion Therapy for detailed information on the following:
 - a. Port protector:
 - i. Do not reuse the port protector, a new one should be used each time it is removed, every 8 hours with routine IV flushing, and PRN.
 - b. Neutral Displacement Connector (i.e. MicroClave).
 - c. Tubing changes.
 - d. Infusion Therapy: Nursing Interventions.
4. Dressing changes shall be performed every seven days in accordance with Patient Care Services: Central Venous Access Devices Procedure for central line dressing changes using central line dressing change kit.

F. BLOOD SPECIMEN COLLECTION:

1. Diagnostic blood draws ("LABS") may be performed through an EDC or Mmidline catheter as follows:
 - a. Identify patient per Tri-City Healthcare District (TCHD) policy.
 - b. Turn off any continuous infusions, disconnect as needed, and ensure all clamps are open.
 - c. Perform hand hygiene and don clean non-sterile gloves.
 - d. Remove port protector from the neutral displacement connector (Microclave) if used.
 - i.e. If a port protector is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time.
 - e.f. Allow injection port to dry, do not fan or blow on port to speed drying.
 - f.g. Flush with 10 mL normal saline; wait 2 minutes.

- g.h.** Place a light venous tourniquet proximal to the catheter tip.
- h.2.** Position arm in gravity dependent position with palm up. Allow 30-60 seconds for venous pooling.
 - i.a.** Draw off and discard 5 mL of blood.
 - i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect blood for discard.
 - ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Reconnect tubing or replace with a new neutral displacement connector
 - iii. Tip: gentle traction on the catheter hub or on the securement device may draw catheter tip away from vessel wall and allow for free flow.
 - 1) If no blood returns, remove neutral displacement connector (with clamp in place), access extension set directly and attempt to aspirate.
 - j.b.** For Direct Transfer Method:
 - i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.
 - ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.
 - k.c.** For Indirect Transfer Method:
 - i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.
 - ii. A safety transfer device must be used to fill the vacuum tube from a syringe.
 - iii. Remove device or syringe and wipe away blood residual.
 - l.d.** Upon completion, flush with 20 mL preservative-free normal saline.
 - m.e.** Reconnect tubing or replace with a new neutral displacement connector being careful not to contaminate the end of the hub.
 - i. Remove gloves, perform hand hygiene, and don a second pair of gloves.
 - ii. Labeling: refer to Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure.
 - iii. Place label(s) on specimen collection tube(s) at patient's bedside.
 - iv. Place specimen collection bag in the designated area for lab to pick up or use tubing system.

G. DRESSING CHANGES:

1. Change the original dressing one day after insertion if newly inserted midline catheter has a gauze dressing.
2. Change transparent dressings with Biopatch disk every 7 days.
 - a. Gauze dressings (including transparent dressings with gauze underneath) shall be changed every two days.
3. Change dressings as needed if they become loose, soiled, or moist.
4. Use the Central Line dressing change kit; the kit has the supplies required for changing an EDC or midline catheter dressing.
5. Explain the procedure to patient.
6. Use Standard Precautions during dressing change (refer to Infection Control: Standard and Transmission- Based Precautions Policy IC.5).
7. Avoid talking over site and have the patient turn away from the site to prevent contamination.
8. Perform hand hygiene, don clean non-sterile gloves, and remove the dressing and discard.
9. Assess insertion site for:
 - a. Signs of infection, i.e. redness, purulent drainage.
 - b. Ensure the securement device and/or sutures are intact.
 - c. Ensure the catheter is not kinked, leaking, or otherwise compromised.
10. Remove non-sterile gloves and perform hand hygiene.
11. Open sterile supplies and don sterile gloves and sterile mask.
12. Perform hand hygiene and don sterile gloves.

13. Apply chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds.
14. Cleanse catheter tubing from exit site to distal end.
15. Allow antiseptic to air dry (do not blow on or fan site) before redressing.
16. Apply transparent dressing with Biopatch.
 - a. Place Biopatch disk around catheter with blue side up and white foam side next to skin at exit site.
 - b. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.
 - c. Center transparent dressing over exit site and the Biopatch disk.
 - d. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.

H. DOCUMENTATION:

1. Document assessments, care and maintenance, and dressing changes in the EHR per the Patient Care Services: Standards of Care, Adults.
2. Document patient education provided and patient and/or caregiver responses in the EHR.

I. REMOVAL:

1. Perform hand hygiene per Infection Control: Hand Hygiene – IC 8 policy.
2. Assemble equipment and supplies.
3. Remove dressing and discard.
4. Grasp catheter near insertion site.
5. Remove slowly, do not use excessive force.
6. If resistance is felt, stop removal, and notify PA or ordering physician and document interventions in the EHR.
7. Document removal of catheter and patient's tolerance in the EHR.

J. POTENTIAL COMPLICATIONS

1. Notify the ordering Physician/AHP for any sign and symptoms of catheter related complications, which may include one or more of the following:
 - a. Infection:
 - i. Fever
 - ii. Chills
 - iii. Swelling, erythema or drainage at insertion site
 - b. Phlebitis:
 - i. Warmth, tenderness, erythema, palpable venous cord
 - c. Thrombosis:
 - i. Leakage from the site
 - ii. Decreased flow rate of infusion pump inability to draw or infuse
 - iii. Edema in areas distal or proximal to the site
 - iv. Swelling in shoulder and neck area or jaw, shoulder or chest pain
 - d. Malposition catheter:
 - i. Lack of blood return
 - ii. Complaints of pain or discomfort in the arm or jaw during infusion
 - iii. Leaking at catheter site
 - iv. Complaints of hearing a swishing sound during infusion
 - e. Catheter breakage:
 - i. Leakage of IV fluid from catheter, hole in the catheter, catheter fracture.
 - 1) In the event of catheter breakage, a tourniquet shall be placed high on the upper arm so that venous flow (not arterial flow) is obstructed.
 - 2) Check vital signs and radial pulse every 5 minutes while the tourniquet is in place.

- 3) Any distress or change in condition should be immediately brought to the attention of the physician.

K. RELATED DOCUMENT(S):

1. Infection Control: Hand Hygiene – IC 8 Policy
2. Infection Control: Standard and Transmission- Based Precautions IC.5 Policy
3. Patient Care Services: Central Venous Access Devices Procedure
4. Patient Care Services: Identification, Patient Policy
5. Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure
6. Patient Care Services: Standards of Care, Adults Procedure

L. REFERENCE(S):

1. Gorski, L. A. (2016). The 2016 infusion therapy standards of practice. Journal of Infusion Nursing.
2. Weigand, D. L. (2017). AACN Procedural Manual for High Acuity, Progressive, and Critical Care, 7th ed. Elsevier, St. Louis, MO

PATIENT CARE SERVICES

ISSUE DATE: 02/89 SUBJECT: Witnessing a Patient Signature on Patient's Personal Documents

REVISION DATE: 06/94, 07/99, 07/02, 03/06, 03/11
05/16, 08/19, 09/22

Patient Care Services Content Expert Approval:	06/2211/25
Clinical Policies & Procedures Committee Approval:	07/2212/25
Nursing Leadership Approval:	08/2201/26
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	09/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/22

A. **POLICY:**

1. Witnessing of signatures on patients' personal documents by hospital personnel shall not be permitted. This policy is for the purpose of avoiding any conflict of interest and to avoid any inference of impropriety.

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

1. Witnessing of Personal Documents

C. **REFERENCE(S):**

1. California Hospital Association Consent Manual 2015
2. California Probate Code

WITNESSING OF PERSONAL DOCUMENTS

TYPE	REQUIREMENT
I. Advance Directives Advance Health Care Directive <ul style="list-style-type: none"> • By law, may not be healthcare providers or employees • Volunteers and Contracted Agencies are agents of hospital for purposes of this policy. 	No witnessing permitted by staff, except Notary Public.
II. Wills Typed Wills: <ul style="list-style-type: none"> • Witnessed by 2 persons who are not beneficiaries under the Will. • Should not be notarized. Holographic Wills: <ul style="list-style-type: none"> • Entirely in patient's own handwriting, dated. • No need to be witnessed. 	Patients or designee will secure their own witnesses. Hospital staff may not witness. No witness required.
III. Financial Documents Real Estate: <ul style="list-style-type: none"> • Notary required. Power of Attorney/Finance Bank Transactions <ul style="list-style-type: none"> • Notary required. 	Notary only. Patient or Designee will secure their own witnesses Hospital staff may not witness. Notary only.

NOTES:

- Witnessing of any patient personal documents by an employee is not permitted.
- Advising patients and visitors regarding legal documents is not permitted.

**ADMINISTRATIVE
DISTRICT OPERATIONS**

ISSUE DATE: 04/19 SUBJECT: Medical Procedures and Interrogations Requested by Law Enforcement

REVISION DATE(S): POLICY NUMBER: 8610-211

Administrative District Operations Content Expert Approval: 07/1709/25
Administrative Policies & Procedures Committee Approval: 07/1810/25
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: 02/1901/26
Administration Approval: 04/1902/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 04/19

A. PURPOSE:

1. To ensure Hospital compliance with State and Federal law while maintaining patients' privacy rights under HIPAA, CA Constitution, and the Fourth Amendment.

B. DEFINITION(S):

1. HIPAA – Health Insurance Portability and Accountability Act (HIPAA) of 1996, privacy regulations published under the Congress of the United States.
2. Fourth Amendment – Fourth Amendment to the United States Constitution, Federal search and seizure law that protects citizens from unreasonable searches by **the government, including** law enforcement, absent specific exceptions.
3. Law enforcement/officer – includes Oceanside, Vista, or Carlsbad Police Officers, Sheriff's Department officers, Detectives, Federal Bureau Investigation, Homeland Security, United States Marshal or other applicable state or federal agents.
4. According to CA Vehicle Code Section 23612 – a code of California Law, law enforcement may perform or request tests, **such as breath, blood, or urine tests** to detect the presence of alcohol or drugs when suspected of driving under the influence. **The testing shall be incidental to a lawful arrest and administered at the direction of a peace officer having reasonable cause to believe the person was driving the motor vehicle "under the influence."** ~~This is also known as according to this Code Section and the "implied consent law". Essentially, the motor vehicle operator "impliedly" gives consent to submit to a blood or breath test. However, This law is considered unconstitutional in accordance with the a US Supreme Court case, *Missouri v. McNeely* (2013) 569 U.S. 141, placed limitations on this practice. Thus, a patient must give clear, willing and voluntary consent. If the person/patient is uncooperative or indecisive regarding his/her consent, the officer must obtain a search warrant or court order. (The CA Implied Consent law is currently under review by CA Supreme Court)~~ **Subsequently, the Court in, *People v. Gutierrez* (2018) Court of Appeal First District, California, ruled that implied consent laws are constitutional, but actual voluntary consent is still required for a warrantless blood draw.**

C. POLICY:

1. A law enforcement officer may bring a person to a hospital and request an evaluation of that person's medical condition and/or request that the hospital perform medical procedures on the person. The person may be a suspect, victim, witness or bystander.

2. In general, physicians and hospital personnel are not required by law to perform medical evaluations or procedures at the request of law enforcement officers.
3. If a state or federal law requires a health care provider to report to law enforcement, then patient-identifiable information may be disclosed to the extent necessary to comply with the reporting law. Thus hospital, physician(s) and others may, without violating health information confidentiality laws, report child abuse, elder abuse, rape, suspicious injuries, etc., to law enforcement officers or agencies. See 45 C.F.R. 164.512, Cal. Pen. Code §§ 11164-11174, 11160-11163.6; and Welf. & Inst. Code §§ 15630-15632. If there are questions regarding the law, please contact the legal department.
 - a. Only the minimum information necessary to fulfill the requirement of the reporting law may be disclosed. There are instances where California law applies and limits the disclosures that would otherwise be permissible under HIPAA.
4. Physicians and other hospital personnel should not perform medical evaluations or procedures request by law enforcement officers except in the following circumstances:
 - a. The patient or legal representative consents;
 - b. A medical emergency exists and the patient does not object to the procedure;
 - c. The officer requests a blood test pursuant to Vehicle Code Section 23612, the request follows the patient's lawful arrest, **but and -the patient must affirmatively gives actual voluntary consent.** If the patient does not consent, a warrant is necessary. If the patient is unconscious or otherwise unable to consent, a valid search warrant or court order is required; **unless exigent circumstances exist.**
 - d. The officer requests a noninvasive medical evaluation to determine if it is medically safe to incarcerate the person; or
 - e. The officer requests the medical evaluation or procedure to be performed pursuant to a valid search warrant and/or court order with judge's signature.
5. If the patient (or legally authorized representative) consents, a physician and/or hospital personnel may perform the medical evaluations or procedures requested by law enforcement. When indicated, the hospital should verify that the person has given informed consent.
6. The California Legislature has stated that adults housed in state prison have the fundamental right to control decisions relating to their own health care. This includes the right to give informed consent.
7. A law enforcement officer may bring an arrested person to the hospital for a limited physical examination to determine if it is medically safe to incarcerate the arrestee. If the patient is brought to TCMC for pre-jail clearance, the hospital performs a medical screening examination. There is no legal requirement for the hospital to communicate any information to law enforcement about the patient. However, the physician may, with the patient's consent, disclose to law enforcement whether the patient is medically cleared and fit for booking.
8. Law enforcement officers may conduct constitutionally permissible searches pursuant to a valid search warrant. The procedures may be performed only if the warrant:
 - a. States a finding of probable cause and
 - b. Specifically describes the person and the procedures to be performed.
9. Law enforcement may request to interrogate a patient in a hospital. If the officer has a court order or a signed search warrant, the hospital should generally permit the officer access to the patient so long as the patient is stable. In addition, if the officer is responding to a crime or an emergency on the facility premises, the hospital also should generally permit the officer access to the patient/s. If the hospital has concerns or questions, contact the legal department.
10. If a competent adult consents to cooperate with law enforcement officers, that person's desire should be respected. A patient who indicates a desire to cooperate with law enforcement should be fully informed by the healthcare provider of any possible adverse medical consequences, and the patient's consent, in light of his or her receipt of such information, should be documented in the medical record as is the Hospital's standard policy before commencing any medical procedure or treatment.

11. Hospitals are generally under no duty to inform law enforcement upon the discharge of a patient, with the exceptions noted which follow. Information about discharge is protected health information by both state confidentiality laws and HIPAA and thus must meet legal requirements for release. Situations which disclosure of discharge information to law enforcement would appear to be permissible are as follows:
 - a. **Under HIPAA's "duty to warn" exception, notification to law enforcement can be made in specific situations where there is a serious and imminent threat of harm to the patient or others.**
 - a.b. When a patient communicates a serious threat of physical violence to a licensed psychotherapist, or other healthcare provider, and it is appropriate that law enforcement be contacted in order to protect the threatened person/s after consulting with the legal department.
 - b.c. Upon discharge or release of a patient who was detained or apprehended for examination of his or her mental condition and who had a weapon confiscated by law enforcement.
 - c.d. Upon the escape/elopement, disappearance, release, or transfer of specified mental health patients,
 - d.e. When a patient is detained for 72-hour evaluation and treatment, and the peace officer who detained the patient did the following:
 - i. Requested notification of discharge when he/she brought the patient in; **AND**
 - ii. Certified in writing that either (i) the patient was referred to the facility under circumstances that support the filing of criminal charges; or (ii) that a weapon was confiscated pursuant to Welfare and Institutions Code section 8102,
 - iii. Only the patient's name, address, date of admission for 72 hour evaluation, date of certification for intensive treatment (if applicable), and date of release may be disclosed.
12. For other circumstances, please consult with the Legal Department, and if necessary the Chief Compliance and Privacy Officer before providing any patient requested information or allowing interrogations by law enforcement officers and consult with Risk Management before performing medical procedures.
13. If an "in-custody" patient or patient under arrest presents to TCMC, medical staff should contact the Security Officer. The Lead Security Officer will make timely contact with any law enforcement and if necessary, conduct a forensic training in-service. The designated security officer is responsible for evaluating the level of security restraint being used to control the "in custody" patient.
 - a. For the safety, security, and welfare of all staff, visitors, and patients, the designated Security Officer will monitor the "in custody" patient during their stay at the Medical Center.
 - b. It is not the responsibility of medical staff to determine the type of restraints needed; however, if any restraints are interfering with medical treatment, attending medical staff must inform the Security Department and the designated security officer will assist in relocating the device to an alternate location on the patient.
 - c. ~~See Administrative Policy: Security Precautions Associated with Incoming In-Custody Patients 219.~~
14. Requests for any hospital video surveillance by law enforcement should be referred to the Legal Department and notify Risk Management.

D. RELATED DOCUMENT(S):

1. Administrative Patient Care Policy: Consent to Photograph and Videotape 8610-372
2. Patient Care Services Policy: Justice Involved Patient
3. ~~Patient Care Services Policy: Assault Victims Domestic Violence Report Requirement~~
- 4.3. Patient Care Services Policy: Reporting Suspected Child Abuse and Neglect
- 5.4. Patient Care Services Policy: Reporting Suspected Dependent Adult Elder Abuse Neglect

6. ~~Security Policy: Security Precautions Associated with Incoming In-Custody Patients 219~~

E. REFERENCE(S):

1. Health Insurance Portability and Accountability Act (HIPAA) of 1996
2. Fourth Amendment to the United States Constitution
3. CHA Consent Manual 2018, Chapter 9, pp. 9.3-9.5
4. CA Vehicle Code Section 23612(a)
5. *Missouri v. McNeely* (2013) 569 U.S. 141
6. 68 Ops.Cal.Atty.Gen. 189 (1985)
7. Welfare and Institutions Code §§ 8102, 15630-15632
8. 45 C.F.R. 164.512
9. Cal. Pen. Code §§ 11164-11174, 11160-11163.6



Tri-City Medical Center

Quality Assessment Performance Improvement (QAPI) Plan 20262024 & 20252027

A. INTRODUCTION:

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

B. MISSION:

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

C. VALUES

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

D. CULTURE OF SAFETY

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

Administrative Content Expert	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/23, 12/23, 12/25	06/23, 01/24, 10/25, 01/26	08/23, 02/24, 12/25, 02/26	n/a	08/23, 02/24, 12/25

- e. Equitable: (e.g. reducing variation in our care, cultural diversity strategy)
- f. Patient Centered: (e.g. Patient Rights and values guide all clinical decisions)

E. **HOSPITAL ORGANIZATION:**

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

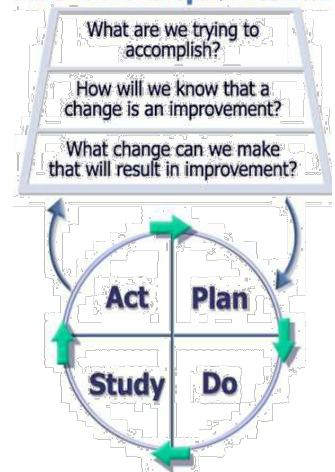
- a. The Quality Assurance/Performance Improvement (QA/PI) Committee, as outlined within its scope of service maintains an active role in the evaluation of quality measures through regularly scheduled meetings.
- b. The following committees will be integrated into the hospital-wide QAPI program for oversight of quality initiatives which includes health outcomes, patient safety, and quality of care:
 - i. Infection Control Committee
 - 1) The Infection Control Committee is a medical staff committee which selects initiatives, monitors and evaluates the Infection Control Program, and reports to the Medical Executive Committee, Medical Quality Peer Review Committee and Quality Assurance/Performance Improvement Committee. The Infection Control Committee is a multidisciplinary committee that shall approve, establish, and oversee the program for surveillance, prevention, and control of infections in order to improve the quality of care provided.
 - ii. Pharmacy and Therapeutics
 - 1) The Pharmacy and Therapeutics (P&T) Committee is a medical staff committee accountable for the safety and quality of medication and therapy as it relates to pharmaceuticals. The committee discusses the hospital formulary and antimicrobial stewardship among other issues.
 - a) The Medication Safety Committee also reports to P&T, which is multidisciplinary. Issues discussed at this level may be referred directly to the MEC, as well as going to the QA/PI Committee for discussion before advancing to the BOD.
 - iii. Patient Safety
 - 1) TCMC maintains an active Patient Safety Program in accordance with TCMC's service standard "Safety". TCMC's Regulatory & Accreditation Manager oversees integration and coordination of patient safety activities, which supports and promotes the mission, vision and values of TCMC. Please refer to the Risk and Patient Safety Plans for additional detail.

F. PERFORMANCE IMPROVEMENT MODEL:

1. FOCUS PDCA:

- a. "PDCA process involves planning for change or improvement constantly, and prioritizing and reprioritizing your improvement efforts based on carefully defined measurements and whether or not the problem involves high-risk, high-volume, or problem-prone processes, and if it dovetails with the goals of the organization" (Dulgacz, Retifo, & Greenwood, 2004).
 - i. F= Find a process to improve
 - ii. O= Organize a team that knows the process
 - iii. C = Clarify current knowledge of the process
 - iv. U= Understand causes of process variation
 - v. S= Select the process improvement
- b. Plan: During this stage, TCMC analyzes and examines services in order to anticipate improvements. This includes collection of data and analysis of the process. The outcome of the "Plan" phase is a list of objectives used to move forward with improvement. Objectives include; appropriate indicators, best practices, and identifying a baseline to measure against. The recommended format for the PDCA cycle is the Institute for Healthcare Improvement (IHI) template. IHI uses the Model for Improvement as the framework to guide improvement work. The Model for Improvement, * developed by

Model for Improvement



Associates in Process Improvement, is a simple, yet powerful tool for accelerating improvement.

- c. Do: In the DO phase, TCMC develops a measure, including the numerator, denominator, sample size and sample population. Also included is how and from what source that data will be gathered. Finally, it identifies the method and frequency of data interpretation and reporting chain (QA/PI, and other committees).
 - d. Check: After gathering data, TCMC analyzes the information and measures the effectiveness of the improvements. This review includes whether data collected was reliable and whether the variation in the studied process is stable. At this point benchmarks and threshold can be reset and any studies modified to better identify any special cause variances. All measures should be analyzed against the baseline data. This stage looks at what improvements were implemented and if they were effective. If the measure needs refinement, the DO phase is revisited at this point.
 - e. Act: The ACT phase is where a refined and perfected process showing a desired outcome is then implemented on a broader scale throughout the organization. In this way success on one unit can beget similar success within the organization. The Act phase circles back to the Plan stage for new implementation, thus ensuring continuous process improvement.
2. TCMC employs a variety of professional resources for benchmarking and identifying best practices including the National Database of Nursing Quality Indicators (NDNQI), the Collaborative Alliance for Nursing Outcomes (CALNOC), Center for Medicare and Medicaid Services (CMS) Value Based Purchasing data, The Joint Commission (TJC)/CMS Core Measure rates, Center for Disease Control (CDC), National Quality Forum (NQF), Agency for Healthcare Research and Quality (AHRQ), Collaborative Healthcare Patient Safety Organization (CHPSO), the Institute for Healthcare Improvement (IHI), the National Healthcare Safety Network (NHSN), the National Association for Healthcare Quality (NAHQ), California Maternal Child Quality Collaborative (CMQCC), California Perinatal Quality Care Collaborative (CPQCC), Health Services Advisory Group Quality Improvement Organization (HSAG QIO), Health Services Advisory Group Improvement Innovation Network (HSAG-HIIN), and other evidence-based sources.

G. **PRIORITIZATION AND PLANNING:**

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

H. DEPLOYMENT:

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

I. PERFORMANCE MEASUREMENT AND MONITORING:

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

J. ERROR PREVENTION, RISK IDENTIFICATION, AND MITIGATION:

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

major medical services/processes. Risk Management and Quality Department and Patient Safety Program manager collect error-reduction data from benchmark healthcare organizations and other industries. This information includes, but is not limited to, the following:

- i. The Joint Commission Sentinel Event Alerts
 - ii. Institute for Safe Medication Practices (ISMP)
 - iii. Medication Safety Alerts
 - iv. Emergency Care Research Institute (ECRI) Bulletins
 - v. CDC Bulletins
 - vi. CMS Hospital Compare Website
3. Utilizing the above data, as well as other internal and external metrics, the Director of Quality, in collaboration with Risk Management, makes recommendations to the Chief Medical Officer and the Quality Assurance/Performance Improvement Committee regarding priority aspects of care processes that are known to be high-risk or problem-prone. Collaboratively these individuals determine priorities for error reduction efforts and charter Teams/Committees to perform process redesign and improvements.

FOOD AND NUTRITION SERVICES

ISSUE DATE: 03/88 SUBJECT: Nutrition Assessment and Care
for Reassessment for Adult
Geriatric Patients (Greater or
Equal to (≥) 18 Years Old

REVISION DATE: 06/08, 10/10, 11/11, 02/12, 03/18,
02/19, 9/2508/22

Food and Nutrition Services Department Approval: 10/2112/25
Medical Staff Department or Division Approval: n/a
Pharmacy & Therapeutics Committee Approval: 07/2212/25
Medical Executive Committee Approval: 07/2201/26
Administration Approval: 08/2202/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 08/22

A. POLICY:

1. ~~A systematic method for the~~ **The Registered Dietitian (RD) to assess the nutrition status and Nutritionist (RDN) performs a systematic and comprehensive nutrition assessment on patients for malnutrition or nutrition-related problems under the** provision of appropriate evidenced based nutrition ~~recommendations~~ **recommendation** and interventions in collaboration with Physician/Allied Health Professional (AHP) and interdisciplinary teams. ~~for patients age fourteen (14) years of age and older admitted to Tri-City Healthcare District. Dietitian consults are auto-generated for criteria within the EMR that may indicate a patient may be nutritionally at risk. RD will assess. Assessment includes establishing nutritional status of consulted patients within 72 hours of receiving consult. considering, but not limited to, age of patient, diagnosis, weight history, nutrition history, medical history, medical therapies/treatments, po intake, laboratory values. RD will assess nutritional risk and complete nutrition assessment form per needs, developing a multidisciplinary care plan and assigning a level of nutrition risk. Patients with higher nutrition risk will be prioritized first. Dietitian will complete Adult Nutrition Assessment form for all patients with LOS greater than seven days without previous Dietitian consult. Reassessments will be completed per level of nutrition risk. Nutrition status will be determined by assessing nutritional pertinent data within the EMR.~~ **care.**

B. PURPOSE:

1. **To ensure timely nutrition assessment of patients of high risk for malnutrition or nutritionally compromised so that appropriate levels of nutritional care can be assigned and implemented. Medical Nutrition (MNT) is provided to support the Physician/AHP with the nutritional care of their patient to maintain or improve nutritional state during admission.**

B-C. PROCEDURE:

1. ~~Dietitian~~ **RDN consults are automatically generated for specific data defined from the Nutrition Screen section of the Adult Patient History Form completed by the admitting RN within 24 hours of admission.**
 - a. **Enteral feeding, TPN, Bariatric Diet, skin breakdown or pressure ulcer, or MST score of 2 of 2 or higher.**

2. ~~Dietitian consults are also automatically generated from Physician Power Plans for diagnosis with significant nutrition needs. The Physician/AHP determine need for Dietitian consult within the Power Plans. A Physician/AHP/RN, family or staff may request nutrition consult at any time during the patients stay and will be completed within 72 hours.~~
3. **A nutrition assessment will be completed on high-risk patients within 48 hours and non-high risk patients within 72 hours of admission.**
4. **Assessment will include interview with patient, family, and staff as appropriate and review of medical record, diagnosis, documented weights, nutrition history, oral intakes of meals, supplements and snacks, educational needs, diet tolerance, laboratory values, and MST score. (Refer to clinical dietitian job descriptions for more details on nutrition assessments.)*****
5. **RDN will make every attempt to conduct Nutrition Focused Physical Exam to assess malnutrition using American Society of Parenteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines, following department protocols.**
- 2-6. **RDN will recommend and document estimated calorie, protein and fluid requirements using evidence base guidelines using TCMC Clinical Inpatient Nutrition Guidelines.**
- 3-7. Any significant change in the patient's condition, i.e. surgery, intubation, or significant change in diagnosis warrants a reassessment. ~~If the RD is not currently following the patient, the~~**The Physician/AHP/Nurse are responsible for entering a Dietitian consult into the EMR-, if RDN is not following patient.**
 - a. ~~Upon receiving Dietitian consult, RD will screen patient to assign nutrition risk. by reviewing the following criteria if available:~~
 - i. ~~Age of patient, diagnosis, weight history, nutrition history, medical history, medical therapies/treatments, po intake, laboratory values, and MST score accuracy.~~
 - b-8. ~~Dietitian will complete a full initial assessment and complete Adult Nutrition Assessment Form for patients with more severe nutrition risk within 72 hours of receiving initial consult and~~**RDN will make every attempt to conduct Nutrition Focused Physical Exam to assess malnutrition using American Society of Parenteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines, following department protocols.**
 - e-9. ~~Patients with lower~~**identified for low** nutrition risk will be seen ~~within~~**on length of stay 7-days and complete Adult Nutrition Assessment Form..**
 4. ~~Dietitian will complete Adult Nutrition Assessment form and include all pertinent and appropriate nutrition data whenever documenting an assessment or reassessment~~
 - a. ~~Dietitian will recommend and document calorie, protein, and fluid requirements using evidenced based guidelines and referencing Nutritional Requirement for Specific Disease States Guide~~
 - 5-10. ~~RDRDN will communicate pertinent nutrition interventions and concerns with Physician/AHP and interdisciplinary team through the Adult Nutrition Assessment Form, Interdisciplinary rounds, or through hospital approved communication.~~
 6. ~~RD will develop, document and execute an evidenced based individualized nutrition plan of care, with appropriate nutrition interventions and individualized goals.~~
 - 7-11. Reassessments with be scheduled per nutrition risk and Dietitian's clinical judgement.
 8. ~~Documentation of changes in the nutrition related problem's signs and symptoms, intervention compliance, and progress towards goals will be addressed and documented upon scheduled reassessment.~~
 - 9-12. It is within the ~~RDRDN~~**RDN** scope to downgraded texture changes when indicated based upon patient tolerance and/or personal preference.
 - 10-13. Obstetric patients will not be assessed unless RD **consult** is requested to be ~~de~~**generated** by Physician/AHP/Nurse-**RN**. (See Food & Nutrition Policy: Nutrition Assessment ~~effor~~ High Risk OB Patient)**patient**)

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

1. Food & Nutrition Policy: **Enteral Nutrition Assessment of High Risk OB Patient**

- ~~2.1. Food &, Enteral Formula Substitute and Total Parental Nutrition Policy: Nutrition Assessment of (TPN Patient)~~
- ~~3.2. Food & Nutrition Procedure: Calorie Count~~
- ~~4. Food & Nutrition Procedure: Enteral Feedings~~
- 5.3. Tri-City Healthcare District Nutritional Requirement for Specific Disease States

B-E. REFERENCE(S):

1. Gottlichlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum*. Kendall/Hunt Publishing Company, Dubuque, IA, 2001.
2. **Nutrition Care Manual of Clinical Dietetics**, online edition. Academy of Nutrition and Dietetics, Chicago, IL, 2017.
3. *Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, ~~2000~~**2025**
4. Mueller, Charles, ed in chief: *The A.S.P.E.N Adult Nutrition Support Core Curriculum*. American Society for Parenteral Enteral Nutrition; ~~2nd~~**3rd** ed. edition (~~2012~~**2017**)
5. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice*. Kendall/Hunt Publ Co, Dubuque, IA, 2002.



FOOD AND NUTRITION SERVICES

SUBJECT: Nutrition Assessment and Care of High Risk OB Patients

ISSUE DATE: 6/00

REVISION DATE(S): 8/05; 11/05; 2/12; 02/13

Food and Nutrition Approval:	04/1809/25
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	11/1912/25
Medical Executive Committee Approval:	01/2001/26
Administration Approval:	02/2002/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/20

A. POLICY:

1. ~~Nursing will generate a referral for nutrition assessment for patients with hyperemesis gravidarum/prolonged diarrhea, hypertension (HTN)/Preeclampsia, skin breakdown or pressure injury, impaired nutritional intake of less than (<) 50% times (X) five (5) days, Bariatric surgery, and/or antepartum gestational, type 1, and type 2 diabetes.~~
 - a. ~~Sweet Success Program:~~
 - i. ~~Registered Dietician (RD) will determine patient's dietary needs; individualize the meal plan based on nutritional assessment and assessment of patients' knowledge of prescribed diet.~~
 - ii. ~~RD to closely monitor food intake, exercise and blood glucose levels to meet glycemic and nutrient intake goals.~~
2. ~~Dietitian will also evaluate nutritional needs for patients upon referral and for other patients with high risk pregnancies, to include: pregnancy induced hypertension; spontaneous rupture of membranes; pre-term labor; incompetent cervix requiring surgical intervention and long term bed rest. Evaluation will entail evaluation of laboratory data, weight history, diet history, and age group.~~
3. ~~Dietitian will monitor intake and adjust diet and food selections as needed during extended admissions.~~
4. ~~Dietitian will educate as appropriate on gestational diabetes; nutritional needs during pregnancy; nutritional needs for infancy (postpartum) and will provide printed guidelines.~~
5. ~~Initial evaluations for high risk pregnancy patients receiving a referral will be documented within forty-eight (48) hours.~~

FOOD AND NUTRITION SERVICES

ISSUE DATE:- 03/88 **SUBJECT:** Nutrition Care for Adolescents for Infants, Pediatrics, & Adolescents

REVISION DATE(S): 10/04, 11/05, 11/07, 7/08, 10/08, 10/10, 11/11, 02/13, 02/20

Food and Nutrition Approval: 04/1809/25
Medical Staff Department/Division Approval: n/a
Pharmacy and Therapeutics Approval: 11/1912/25
Medical Executive Committee Approval: 01/2001/26
Administration Approval: 02/2002/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 02/20

A. DEFINITIONS:

1. Malnourished or Nutritionally at Risk:
 - a. Acute wt. loss of greater than 10% of body wt.
 - b. Wt. for height/length below 5th percentile on growth chart.
 - c. Decreased % scores of ht. and/or Wt (Wt/length <3% or greater than >97% when compared to growth charts.)
 - d. Increased metabolic requirements.
 - e. Low birth wt. or prematurity.
 - f. Inadequate provision or tolerance of nutrients.
 - g. Failure to thrive
 - h. Poor oral intake or delays in chewing, swallowing
 - i. Primary nutritionally related medical condition (e.g. diabetes mellitus, metabolic disorder, congenital heart defect, GI condition)

B. POLICY

1. Function: A systematic method for the Registered Dietitian to collaborate with the physician in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements.
2. Circumstances:
 - a. Setting: All infant, pediatric and adolescent patients admitted to or being treated at Tri City Medical Center
 - b. Supervision: None required
 - c. Referrals for a nutrition assessment are generated if certain criteria are met via the admission assessment in the electronic health record (EHR).
 - d. Registered dietitians (RD) will assess nutritional status of triggered patients within 48 hours of referral, considering age of patient, disease states, nutrition history, medical history, medical therapies/treatments and laboratory values.
 - e. Registered dietitians (RD) may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, changes in food texture and consistency, and education of patients/families regarding appropriate nutrition intervention for a particular disease state.

C. PROCEDURE:

1. Referrals for nutrition assessment are generated if the following criteria are met upon completion of the pediatric admission data base: currently receiving TPN/enteral feedings; unplanned weight loss; presence of pressure ulcer or skin breakdown; eating disorder; impaired nutrient intake, nausea/vomiting/diarrhea; intake of less than 50% normal in 3 days; aspiration risk; and BMI of <3% or >97%. Additional criteria for infants and pediatric patients include: wt/length < 3% or >97% on growth charts, difficulty with suck/swallow; poor weight gain; failure to thrive and presence of enteral tube/button. The dietitian will complete the assessment with consideration of:
 - a. ~~Diet order~~
 - a. Diet order
 - b. Diagnosis
 - c. Chronological age and/or gestational age
 - d. Weight
 - e. Height or length
 - f. Head circumference as appropriate
 - g. Food allergies
 - h. Diet prior to admission
 - i. Birth weight - if available
 - j. History of weight changes
 - k. Potential drug nutrient interactions
 - l. Labs and biochemical values: to include, among others, serum albumin, Hgb, Hct, MCV
 - m. Feeding problems such as chewing, swallowing, and appetite changes.
 - ~~n.~~ n. Nutrition/diet history
 - o. Psychosocial, physiological, social or environmental issues
 - p. Clinical assessment changes
 - q. Any other general nutrition concerns.
2. Clinical dietitian will document nutrition assessment in the EHR- on Initial Pediatric Nutrition Assessment power form. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, and other disciplines' notes, and interview with patients, parents, or nursing:
 - a. Diet order
 - b. Diagnosis
 - c. Age
 - d. Weight, height, anthropometrics
 - e. Growth failure/growth deviation
 - f. Food allergies
 - g. Labs: pertinent to assessment
 - h. Pertinent drug nutrient interactions
 - i. History of weight changes
 - j. Feeding problems such as chewing, swallowing, appetite
 - k. Psychosocial, physiological, social or environmental issues
 - l. Nutrition/diet history, including cultural food preferences
 - m. Pregnancy
3. Clinical Dietitian will document assessment in the EHR. The Dietitian will also calculate the following:
 - a. Weight for height percentile or weight for age/weight for height percentile.
 - b. BMI percentile
 - c. Head circumference percentile, as appropriate
 - d. Weight change percentile
 - e. Estimation of calories and is based on the child's age, gender, weight, disease state, & nutrition status.
 - f. Grams of protein per day.
 - g. Fluid requirements

4. A nutrition care plan will be developed and individualized based on assessment and will meet specific needs of patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames.
5. Normally nourished patients who have adequate intake to satisfy nutrient requirements will be monitored ~~on an~~ **at least every 3** - 4 day follow-up basis or as indicated by nursing/MD referral.
5. Malnourished children will be followed daily, with documentation at least every 4 days, until intake is adequate to meet needs.
6. Normally nourished children with inadequate intake may require nutrition intervention/support after 5 days of inadequate nutritional intake, depending upon age, medical condition, and nutritional status. Malnourished children who have inadequate intake may require nutrition support (i.e. parenteral or enteral nutrition) after 1-3 days of inadequate nutrition intake depending upon age, medical condition, and nutritional status. These patients will be monitored on a 1-3 day follow-up basis or as indicated by referral.

Estimated Energy and Protein Requirements/Dietary Reference Intakes			
Age (yr)	Protein g/kg/d	Kcal/Kg/d	Kcal/d
0.0-0.5	2.2	108	Kg x 108
0.5-1.0	1.5	98	Kg x 98
1-3	1.3	102	1300
4-6	1.2	90	1800
7-10	1.0	70	2000
Males:			
11-14	1.0	55	2500
15-18	0.9	45	3000
Females:			
11-14	1.0	47	2200
15-18	0.8	40	2200

7. Clinical Dietitian will confer with MD, RN, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, Braden Score, etc.).
8. Clinical Dietitian will provide and document follow-up visits for patients assessed at risk as necessary or at least every four (4) days depending on medical and nutritional status and will revise therapy as indicated. Follow up visits may be requested by physicians and/or nursing and other members of the health care team. Patients with adequate intake will be followed throughout their stay with documentation in the medical record within at least seven (7) days. Follow-up assessment is documented on the Nutrition Reassessment power form, to include nutrient intake, tolerance to diet, weight changes, laboratory parameters, and I&O. Follow-up assessments may be triggered sooner as warranted by a change in medical condition, surgical intervention, changes in nutrient intake or nutrition status.
9. Clinical Dietitian will provide nutrition counseling and education explaining rationale to patient/parent/significant other as ordered by physician, as requested by nursing, or family, or as deemed appropriate by RD. Education information is reflected in the Patient/Family education section of the ~~power forms~~ **power forms** grid. Referrals will be made for outpatient medical nutrition therapy as appropriate. Information about available community resources will be provided.

10. Standard adult menus and snacks are utilized. If enteral formulas are required, adult formulas are utilized for children >14 years old; Specialty enteral formulas can be utilized as necessary
10. dependent upon disease state, medical condition, gastrointestinal tolerance and ability to absorb nutrients view, Nutrition Care & Assessment for Infants Admitted to NICU for infant recommendations.

D. **REFERENCE LIST**

1. ~~“The Science and Practice of ASPEN Pediatric Nutrition Support” ed. Gottschlich, Core Curriculum. Corkins MM; 2001.~~ **2022.**

INFECTION CONTROL

ISSUE DATE: 07/03

SUBJECT: Hand Hygiene

REVISION DATE: 04/08, 07/11, 12/14, 07/17, 06/20
05/23

Infection Control Department Approval:	12/22 11/25
Infection Control Committee Approval:	04/23 12/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	04/23 01/26
Administration Approval:	05/23 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/23

A. PURPOSE:

1. The purpose of hand hygiene is to remove microorganisms and reduce the risk of transmitting disease and/or significant pathogens to patients, healthcare workers, environment, and visitors.

B. GENERAL INFORMATION:

1. Hand hygiene is the single most important activity for preventing transmission of infectious microorganisms.
2. Multiple studies have shown that the hands of healthcare workers carry large numbers of germs. Transient flora are acquired from patients or contaminated environmental surfaces and are more likely to cause healthcare-associated infections than resident flora – bacteria always found on the skin. Normal shedding of skin cells spreads germs that are carried on the skin.

C. POLICY STATEMENTS:

1. Length of nails/Fingernail polish/ Artificial nails:
 - a. Fingernails must be less than ¼ inch in length, clean and trimmed. Long natural nails carry twice the number of germs compared to short (less than ¼ inch) natural fingernails.
 - b. Fingernail polish is permitted as long as there is no chipping or peeling. Freshly applied nail polish does not increase the number of bacteria but chipped nail polish may support the growth of larger numbers of organisms on fingernails.
 - c. Pursuant to Center for Disease Control (CDC) guidelines and the World Health Organization (WHO), all health care workers and providers who provide direct “hands on” patient care cannot wear artificial fingernails, nail extenders/tips or nail jewelry.
2. Wearing gloves does not provide complete protection against microorganisms. Up to 30% of healthcare workers who wear gloves during patient contact will be carrying germs from the patient they just touched after the gloves are removed. Bacteria and viruses gain access to their hands through small holes in gloves and/or during glove removal.
3. Indications for hand washing and hand antisepsis:
 - a. Wash hands with hospital-approved soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material (all body fluids except sweat).
 - b. If hands are not visibly soiled, may use an alcohol-based waterless antiseptic agent.
 - c. Perform hand hygiene before and after patient contact.
 - d. Perform hand hygiene after contact with a patient’s surroundings/ environment.
 - e. Perform hand hygiene after contact with body fluids or excretions, mucous membranes, intact and non-intact skin, or wound dressings.
 - f. Perform hand hygiene before performing an aseptic task.

- g. Perform hand hygiene before accessing and inserting invasive devices.
- h. Perform hand hygiene before preparing and administering medication.
- i. Perform hand hygiene before donning gloves and after removing gloves.

D. HAND HYGIENE TECHNIQUES:

- 1. Waterless Based Products:
 - a. When decontaminating hands with a waterless alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
 - b. If an adequate volume of an alcohol-based hand rub is used, it should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use.
- 2. Soap and Water:
 - a. When washing hands with soap, wet hands first with warm water, apply 3 to 5 ml of detergent to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet.
- 3. Gloves:
 - a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur.
 - b. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients.
 - c. Change gloves during patient care if moving from a contaminated body site to a clean body site.
 - d. Perform hand hygiene after glove removal.
- 4. Surgical Hand Antisepsis
 - a. See Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis for details.

E. RELATED DOCUMENT(S):

- 1. Administrative - Human Resources Policy: 8601-415 Dress and Appearance Philosophy Policy
- 2. Patient Care Services Policy: Surgical Services: Surgical Attire Policy
- 3. Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis

F. REFERENCE(S):

- 1. Center for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee: HICPAC/SHEA/APIC/IDSA MMWR 2002; Vol.51 (**Reviewed 11/18/25**)
- 2. WHO Guidelines on Hand Hygiene in Health Care 2009 (**Reviewed 11/18/25**)
- 3. **Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC** (**Accessed 11/18/25**)<https://www.cdc.gov/handhygiene/providers/index.html>

INFECTION CONTROL

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

REVISION DATE: 04/09, 05/12, 09/15, 09/18, 05/22
09/18, 01/24, 02/23, 03/24, 02/25

Infection Control Department Approval: ~~10/24~~10/25
Infection Control Committee Approval: ~~10/24~~12/25
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: ~~01/25~~01/26
Administration Approval: ~~02/25~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 02/25

A. PURPOSE:

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

B. GOALS:

1. Overall
 - a. Reduce risk of healthcare-associated infections for all patients, employees, and visitors.
2. Targeted
 - a. Healthcare-associated infection reduction – at least 30% reduction overall across the infection types that are reported to CMS (MRSA bacteremia, *C.difficile*, CLABSI; SSI Hysterectomy and Colon surgery; CAUTI). (Note: infection counts are based on CMS required reporting regulations, not necessarily all hospital-wide infections)
 - b. Hand hygiene compliance program
 - i. Incorporate patients and families
 - 1) Develop a bundle of tools for patients and family involvement
 - ii. Consistently sustain ≥ 96 percent compliance across locations and job classes
 - 1) At least 96 percent of all locations and job classes must sustain 96 percent compliance or higher (for all locations/job classes submitting at least 40 observations/month)
 - iii. Promote engagement
 - 1) Develop tools for promoting involvement across all job categories
 - 2) develop new incentives and rewards.

C. RISK ASSESSMENT:

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

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

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

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

- e. Enlist organizational leaders to serve as role models.
 - f. Ensure commitment of leadership to achieve and sustain compliance of $\geq 96\%$.
6. Develop and Support Infection Control Liaison Program
- a. Unit-based staff, outpatient care services clinical staff, and ancillary care staff (i.e., EVS, FNS, Patient Transport) with focused infection control training provided by Infection Prevention.
 - b. Responsible for assessing their unit's compliance with infection control policies/procedures and conducting performance improvement activities related to infection prevention (e.g., reducing device-associated infections, monitoring and improving hand hygiene compliance)
 - c. Serves as the contact person to disseminate infection control information, updates, and answer staff questions
7. Ensure compliance with TJC National Patient Safety Goals
- a. Comply with WHO/CDC hand hygiene guidelines
 - b. Prevent HAIs due to multi-drug resistant organisms (MDROs)
 - i. Annual risk assessment for MDROs
 - ii. Implement and assess prevention strategies outlined in this plan and under NPSG 07.03.01
 - c. Assess compliance with evidence-based practices for prevention of central line-associated bloodstream infections
 - i. Compliance with Central Line Insertions, Access, and Maintenance Bundle
 - ii. Standardized insertion training and checklist for providers.
 - iii. Chlorhexidine bathing in intensive care units, and for all patients hospital-wide with a central line.
 - iv. Daily assessment for central line need
 - v. Provide Central Line-Associated Bloodstream Infection rate data and prevention process measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians
 - d. Assess compliance with evidence-based practices for prevention of surgical site infections
 - i. Ensure patient education provided in Pre-op visit. Use LMS for staff education.
 - ii. Promote standardized, evidence-based practices for patient skin preparation prior to surgery.
 - iii. Ensure Peri-Operative Services and Anesthesia infection control policies support prevention strategies.
 - iv. Trend surgical procedure specific infection rates and unit rates and provide feedback to key stakeholders
 - e. Implement evidence-based strategies for prevention of catheter-associated urinary tract infections
 - i. Staff education regarding aseptic insertion of catheter
 - ii. Insertion order must include indication for catheter
 - iii. Daily assessment for urinary catheter need
 - iv. Appropriate maintenance of indwelling urinary catheters
 - v. Perform periodic audits on Indwelling Urinary Catheter Maintenance compliance and removal protocol and disseminate process measures on compliance to unit leadership quarterly.
8. Manage HAIs as Sentinel Events When Indicated
- a. Review all HAIs for indications of an unanticipated death or permanent loss of function
 - b. Notify Risk Management of suspected sentinel event
 - c. Participate in root cause analysis and follow up as needed
9. Construction Rounds and Construction Risk Assessment Meetings

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

E. SPECIFIC STRATEGIES TO ADDRESS INFECTION RISKS:

1. Based on the Facility Risk Assessment, the following strategies will be employed in FY24 for elements with scores of >6:
 - a. Environmental Cleanliness-Terminal Cleaning failure
 - i. Staff education and competency check off
 - ii. Weekly documented IP oversight
 - iii. Implementation of unit specific terminal cleaning checklist
 - b. Personal Protective Equipment (PPE) Compliance

- i. Compliance monitoring
- ii. Staff education and competency check-off

F. **EVALUATION OF PLAN EFFECTIVENESS:**

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

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

1. Infection Control Policy: Infection Prevention Risk Assessment
2. Infection Prevention Risk Assessment Table
3. Infection Prevention Program Evaluation

H. **REFERENCE(S):**

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

INFECTION CONTROL

ISSUE DATE: 01/85 **SUBJECT:** Meningococcal Exposure

REVIEW DATE: 09/03, 10/04, 09/07, 08/14, 03/17,
02/20, 05/23

Infection Control Department Approval: ~~12/22~~11/25
Infection Control Committee Approval: ~~04/23~~12/25
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: ~~04/23~~01/26
Administration Approval: ~~05/23~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 05/23

A. PURPOSE:

1. To help prevent the transmission of disease to and colonization of healthcare workers (HCWs).
2. Health care workers may require prophylactic antibiotics after a significant exposure to a patient with an infection (meningitis, bacteremia, or pneumonia) due to *Neisseria meningitidis*. Bacterial meningitis infection presents as a sudden onset of fever, headache, and stiff neck. The symptoms of bacterial meningitis can appear quickly or over several days. Typically they develop within 3 – 7 days after exposure.
3. Prophylaxis is most effective within the first 4 days post-exposure.
4. Patient is placed in Droplet Precautions if disease is known or suspected before lab confirmation.
5. Chemoprophylaxis is offered to HCWs if:
 - a. the patient's CSF gram stain is positive for gram negative diplococci, or blood, sputum, or CSF is culture positive for *Neisseria meningitidis* and
 - b. (2) HCW had an "intimate exposure" as defined on the Meningococcal Meningitis worksheet (Appendix A), was not wearing appropriate PPE, and the patient was not receiving appropriate antibiotics for at least 24 hours.
 - c. Staff Roles (See hyperlink for flow chart):
 - d. Microbiology: report significant stains and cultures to patient's attending physician, public health and Infection Preventionist (M – F ~~7:30~~8am to ~~3:30~~5pm) or the Administrative Supervisor after hours and weekends.
 - e. Infection Preventionist or Administrative Supervisor: assist in identification of departments or units involved and report to San Diego County Health and Human Services Epidemiology department: # (619) 692-8499 FAX # (858) 715-6458
 - f. Charge Nurse: review the patient's chart to identify exposed staff. Complete and send attached Meningococcal Meningitis Worksheet (Appendix A) to Employee Health.
 - g. ED Base Coordinator to 1) fill out Communicable Disease Exposure Report Form (from County of San Diego Public Health Department: Division of Emergency Medical Services 2) send form to Infection Control staff for follow up 3) notify the EMS agency's Infection Control Officer of exposure.
6. Exposed employee: complete an Injury/Illness Investigation Report and sign in to be seen in Emergency Department.

B. RELATED DOCUMENT(S):

1. Meningococcal Meningitis Worksheet
2. *Neisseria* Meningitis Exposure Flowchart

C. **REFERENCE(S):**

1. ~~Centers for Disease Control and Prevention. (2025, August 7). *ACIP recommendations*. <https://www.cdc.gov/acip/vaccine-recommendations/index.html> (Accessed 11/25/25)~~ APIC, Ready Reference to Microbes, Washington DC: 3rd Edition. Brooks, K, 2012
- 2.1. APIC, APIC Text of Infection Control and Epidemiology, Washington, DC: 4th Edition. Association for Professionals in Infection Control and Epidemiology, 2014.
3. ~~County of San Diego Health & Human Services Agency. (2025, July 3). *Health advisory: Increased invasive meningococcal disease (IMD), San Diego County*. https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/cahan/communications_documents/7-3-2025.pdf (Accessed 11/25/25)~~ Gilmore A, Stuart J, Andrews N, Risk of secondary meningococcal disease in health-care workers. Lancet 2000, 11;356(9242): 1654-1655.
4. ~~**Meningococcal Disease Quicksheet (Accessed 11/25/25)**~~
~~<http://www.cdc.gov/meningitis/bacterial.html>~~
- 5.2. Centers for Disease Control and Prevention. Occupational transmission of Neisseria meningitidis — California, 2009. MMWR Morb Mortal Wkly Rep. 2010;59(45):1480-1483.
(Reviewed 11/22(Accessed 11/25/25))

**Tri-City Health Care District
Oceanside, California**

Meningococcal Meningitis Worksheet

Charge Person/Department Manager: _____

Date: _____ Time: _____ Patient's MR# _____

Staff Involved:

Exposed

Staff Involved:	Exposed	
1.	Y	N
2.	Y	N
3.	Y	N
4.	Y	N
5.	Y	N
6.	Y	N
7.	Y	N
8.	Y	N
9.	Y	N
10.	Y	N
11.	Y	N
12.	Y	N
13.	Y	N
14.	Y	N
15.	Y	N

Exposure is defined as intimate and unprotected (no mask or face shield) contact with a patient with meningococcal disease (*Neisseria meningitis*) prior to antibiotic administration for at least 24 hours. There is a negligible risk of disease following casual contact. The following are examples of an "exposure"

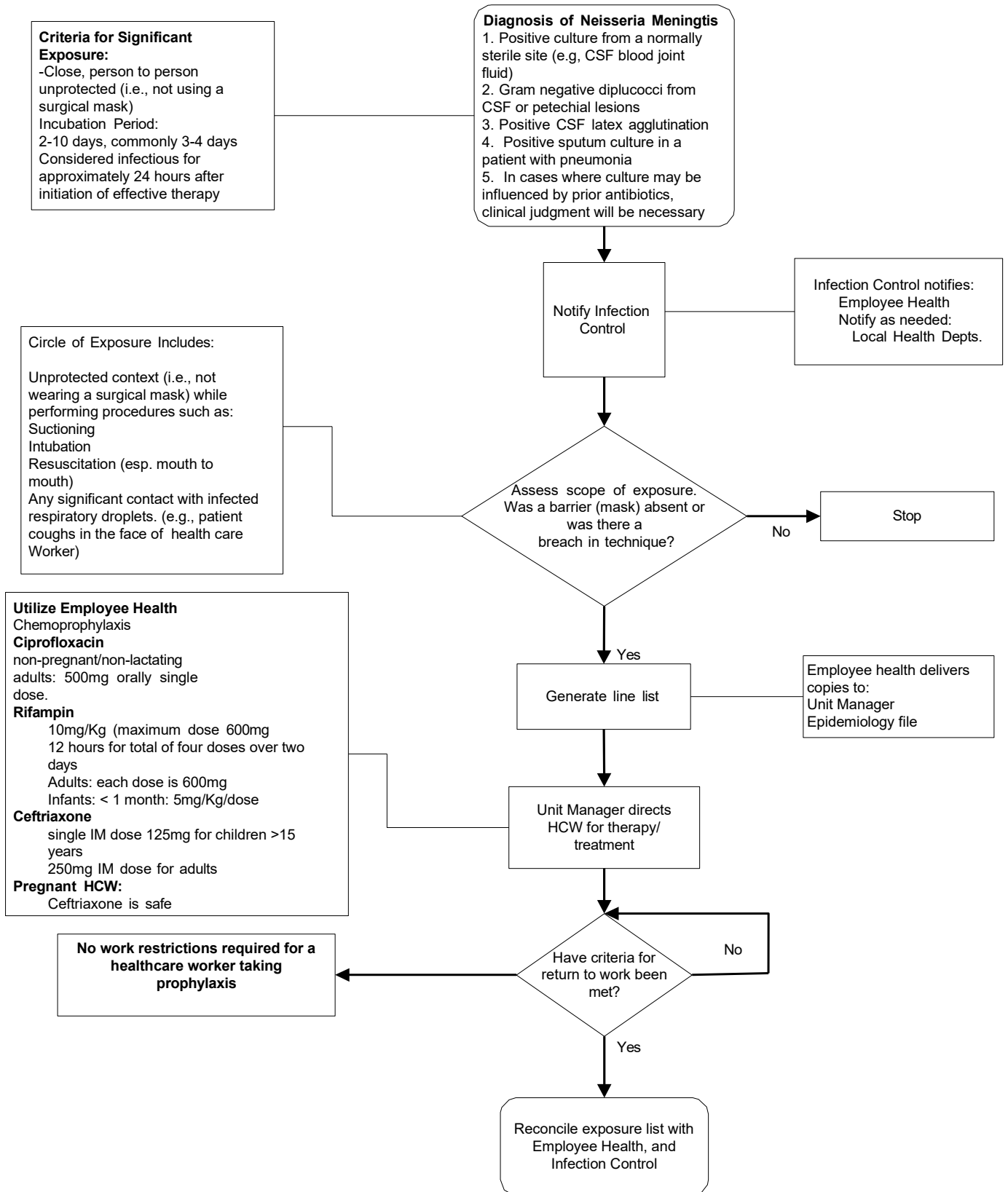
Mouth to mouth resuscitation
Suctioning without using personal protective equipment (mask and goggles or face shield)
Participation in intubation without using personal protective equipment (mask and goggles or face shield)
Oral or endoscopic examination without using personal protective equipment (mask and goggles or face shield)
Assisting with vomiting patient without using personal protective equipment (mask and goggles or face shield)
Other mucus-membrane contact with respiratory secretions.

All staff identified as "exposed" are directed to the Emergency Department for further evaluation and possible prophylactic treatment.

Please fax the completed form to Employee Health Services at (760) 940-4005.

Healthcare Worker Exposure to Neisseria Meningitis

This algorithm does not need to be done on every case of exposure to Meningitis only for exposure to Neisseria Meningitis



INFECTION CONTROL

ISSUE DATE:	11/99	SUBJECT: Standard and Transmission-Based Precautions
REVISION DATE:	10/05, 01/11, 09/15, 01/17, 08/17, 07/18, 08/19, 02/23	
Infection Control Department Approval:	11/22 11/25	
Infection Control Committee Approval:	11/22 12/25	
Pharmacy & Therapeutics Committee Approval:	n/a	
Medical Executive Committee Approval:	01/23 01/26	
Administration Approval:	02/23 02/26	
Professional Affairs Committee Approval:	n/a	
Board of Directors Approval:	02/23	

PURPOSE:

1. The Center for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of Personal Protective Equipment (PPE) prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

POLICY:

1. For immunocompromised patients see Patient Care Services: Neutropenic Precautions Policy.
 - a. Use Standard Precautions, with emphasis on hand hygiene.
 - b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
 - c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
 - a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be ordered for the patient.
 - b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and gown based upon anticipated contact with infectious materials.
 - c. Physicians should be aware of their current vaccination status regarding (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.
3. The role of nurses and other direct care providers is to:
 - a. Assure that isolation orders are entered and proper isolation signage is posted outside of the patients' room.
 - b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding

gloves and washing hands after touching any body substance. Direct care providers need to evaluate their interaction with the patient and use barriers such as masks, eyewear, and gown based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

- c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.
 - d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.
 - e. The nurse and or caregiver is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the Off Unit Transfer/Assessment: Type of Isolation/Precautions in the Electronic Medical Record (EMR)
4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB ~~skin testings~~**screening** program. This participation is required by the hospital.
 5. All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center (TCMC).
 - ~~6.~~ **Specimen Labeling**
 - ~~7.~~**6.** Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients' diagnosis. Standard precautions need to be utilized while handling all specimens. (Handling of soiled linen from patients' rooms
 - a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.
 - ~~8.~~**7.** Dishware and eating utensils
 - a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.
 - ~~9.~~**8.** Disposal of waste from patients' rooms
 - a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.
 - ~~10.~~**9.** All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:
 - a. Obtain a red "biohazardous" plastic bag from the soiled utility room.
 - b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.
 - c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.
 - d. All suction canister liners and tubing should be changed every 24 hours or when $\frac{3}{4}$ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.
 - ~~11.~~**10.** Wound Dressings
 - a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids, gauze or cotton balls used in fingerstick glucose testing,
 - b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the

glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucous membranes and non-intact skin.
 - a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucous membranes.
2. Elements of Standard Precautions
 - a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
 - b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
 - i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
 - c. Gloves
 - i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
 - ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
 - iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
 - iv. Perform hand hygiene immediately after removing gloves.
 - d. Masks, Eye/Face Shields
 - i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Standard Precautions: Personal Precautions Equipment Table)
 - ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
 - e. Gown
 - i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
 - i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
 - ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene after glove removal
4. Patient Care Equipment
 - a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.
 - b. Ensure that reusable equipment is properly cleaned and disinfected before it is used for the care of another patient.
 - c. Single use items should be discarded.
5. Environmental Control
 - a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.

6. Safe injection practices – see Patient Care Services: Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
 - a. Use aseptic technique to avoid contamination of sterile injection equipment.
 - b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
 - c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer’s recommendations; discard if sterility is compromised or questionable.

TRANSMISSION-BASED PRECAUTIONS:

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
 - a. Types of Transmission-based Precautions:
 - i. Airborne Precautions
 - ii. Droplet Precautions
 - iii. Contact Precautions
 - b. See Type and Duration of Precautions - Disease Specific (FKA Short Sheet - <https://tcmc.ellucid.com/documents/view/4323>).
 - c. Communicate and notify receiving department/services if patient requires Transmission-based Precautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
 - a. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
 - b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
 - c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
 - d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
 - a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
 - b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
 - c. Wear masks when entering the patient room.
 - d. Mask patients during transport.
4. Contact Precautions
 - a. In addition to Standard Precautions, use Contact Precautions for specified patients known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients’ environment such as MRSA and VRE. (See Infection Control Policy: Management of Patients with MDRO’s)
 - b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, **indwelling** foley **catheter**, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with Infection Prevention staff is advised when there are questions about patient placement.
 - c. Gloves

- i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails). Don gloves upon entry into the room or cubicle and continue to follow Standard Precautions.
- d. Gowns
 - i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle and continue to follow Standard Precautions.
 - ii. Remove gown and gloves and perform hand hygiene before leaving the patient-care room or environment
- e. Dedicate the use of non-critical equipment to a single patient, when possible
- f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant
- g. Patient transport
 - i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

E. **PREGNANT HEALTH CARE WORKERS:**

1. Pregnant healthcare workers are not more likely to contract infections from patients.
2. Unless a pregnant healthcare worker is susceptible to a patient's infection, the HCW will provide the same care as provided by non-pregnant worker.
3. Restricting pregnant HCW from caring for patients with potentially transmissible infections is considered only for patients with parvovirus B19 and for patients with respiratory syncytial virus infections who are receiving ribavirin aerosol.

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

1. Infection Control Policy: ATD: Tuberculosis Control Plan
2. Infection Control Policy: Blood borne Pathogen Exposure Control Plan
3. Infection Control Policy: Ebola Plan
4. Patient Care Services Policy: Medication Administration
5. Patient Care Services Policy: Neutropenic Precautions
6. Type and Duration of Precautions - Disease Specific (AKA Short Sheet)

G. **REFERENCE(S):**

1. Centers for Disease Control and Prevention. (2024). III. Precautions to prevent transmission of infectious agents. Infection control. <https://www.cdc.gov/infection-control/hcp/isolation-precautions/precautions.html> (Accessed 11/25/25)Centers for Disease Control and Prevention (2007). CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting. Retrieved from <https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html> Accessed 5-14-19

2. Grotta, P. (Ed.). (2021). *APIC text of infection control and epidemiology* (6th ed., Chapter 29, Isolation Precautions). Association for Professionals in Infection Control and Epidemiology. (Accessed 11/25/25)Grotta, P. (Ed.). (2014) *APIC Text of Infection Control and Epidemiology* (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.

3. Schulster, L. M., Chinn, R. Y. W., Arduino, M. J., Carpenter, J., Donlan, R., Ashford, D., Besser, R., Fields, B., McNeil, M. M., Whitney, C., Wong, S., Juranek, D., & Cleveland, J. (2003). Guidelines for environmental infection control in health-care facilities: Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC) (Updated July 2019). U.S. Department of Health and Human Services,

Centers for Disease Control and Prevention. <https://www.cdc.gov/infection-control/media/pdfs/guideline-environmental-h.pdf> (Reviewed 11/25/25) Schulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004. https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental_guidelines.pdf Accessed 5-14-19

~~2. Siegel JD, Rhinchart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 <https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf> Accessed 5-14-19~~

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

A. CONTACT PRECAUTIONS:

1. For illnesses easily passed by direct contact with the patient or equipment. Private room if available, **or mandated (MDRO specific)**. Cohort with others with same organisms. Do not place with fresh post-op or patients with invasive tubes. HCW wear gloves in the room and add a gown if clothes might touch objects or the patient. Use a mask is to protect your face from sprays or splashes.

~~1.~~

CONTACT PRECAUTIONS

If patient has diarrhea and/or C.difficile add Contact Enteric Precautions.
Display sign outside the door. At patient discharge, remove sign after room is terminally cleaned.

Common Conditions:

- Highly drug-resistant organisms
 - Carbapenem resistant Gram-negative rods/ESBL
 - Methicillin-resistant Staphylococcus aureus (MRSA)
 - Vancomycin-resistant Enterococcus (VRE)
- Scabies
- Wounds or abscesses with uncontained drainage

Dishes/utensils:
No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Only essential equipment and supplies in room.
- Use dedicated or disposable equipment when available.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.

Linen Management:
Bag linen in patient's room.

Personal Protective Equipment:

Standard and Tear-away Gown	Three-part Gown
Put ON in this order: <ol style="list-style-type: none">1. Wash or gel hands2. Gown3. Gloves	Put ON in this order: <ol style="list-style-type: none">1. Wash or gel hands2. Gown3. Gloves
Take OFF & dispose in this order: <ol style="list-style-type: none">1. Gloves2. Gown3. Must wash with soap and water (even if gloves used)	Take OFF & dispose in this order: <ol style="list-style-type: none">1. Gown and gloves at the same time (grab gown and pull off gloves in one movement)2. Must wash with soap and water (even if gloves used)

Private Room:
If not available, please follow facility policy when cohorting patients

Room Cleaning:
Follow facility policy for Contact Precautions disinfection and curtain change requirements.

Transport:
Essential transport only. Have patient wear a surgical mask. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

Discontinue precautions as per Facility Policy or Infection Prevention and Control Team

B. DROPLET PRECAUTIONS:

- ~~1.~~ For illnesses passed in large droplets (wet drop to wet mucus membrane contact). Private room if available. Cohort with others with same organisms. HCW wear a mask when closer than 3 ft. to the patient. Surgical masks for visitors going closer than 3 ft. to the patient and for patients outside the isolation rooms.

1.

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

DROPLET PRECAUTIONS

If patient has diarrhea and/or C.difficile add Contact Enteric Precautions. Display sign outside the door. At patient discharge, remove sign after room is terminally cleaned.

Common Conditions:

- Influenza
- Meningitis
- Pertussis
- Respiratory viruses
- Mumps

Dishes/utensils:
No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Only essential equipment and supplies in room.
- Use dedicated or disposable equipment when available.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.

Linen Management:
Bag linen in patient's room.

Personal Protective Equipment:

Standard and Tear-away Gown	Three-part Gown
Put ON in this order: 1. Wash or gel hands 2. Gown (if needed) 3. Mask 4. Eye cover (if needed) 5. Gloves	Put ON in this order: 1. Wash or gel hands 2. Gown 3. Mask 4. Eye cover (if needed) 5. Gloves
Take OFF & dispose in this order: 1. Gloves 2. Eye cover (if used) 3. Gown 4. Mask (if used) 5. Must wash with soap and water (even if gloves used)	Take OFF & dispose in this order: 1. Gown and gloves at the same time (grab gown and pull off gloves in one movement) 2. Eye cover (if used) 3. Mask 4. Must wash with soap and water (even if gloves used)

Private Room:
If not available, please follow facility policy when cohorting patients

Room Cleaning:
Follow facility policy for Droplet Precautions disinfection and curtain change requirements.

Transport:
Essential transport only. Have patient wear a surgical mask. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

Discontinue precautions as per Facility Policy or Infection Prevention and Control Team

C. **AIRBORNE PRECAUTIONS:**

- For illnesses passed in the air. Place in a negative pressure room (C26, ~~143, 243, 443, 243, 443, 287, 301, 312, 326, 387, 387, 443, 487, 200, 201, 301, 312 & 326~~) Keep the door closed at all times. HCW wear N95 respirators in the patient's room. Surgical masks for visitors going into the isolation room and for patients outside the isolation rooms.

AIRBORNE PRECAUTIONS

If patient has diarrhea and/or C.difficile add Contact Enteric Precautions. Display sign outside the door. At patient discharge, remove sign after room is terminally cleaned.

Common Conditions:

- Pulmonary or laryngeal tuberculosis
- Novel organisms as designated by CDC

Prefer Family and Visitors to visit only if previously exposed

Airborne Infection Isolation Room:
Comply with Facility Policy regarding airflow monitoring.

Dishes/utensils:
No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Only essential equipment and supplies in room.
- Use dedicated or disposable equipment when available.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.

Linen Management:
Bag linen in patient's room.

Personal Protective Equipment:

Put ON in this order:	Take OFF & dispose outside room in this order:
1. Wash or gel hands 2. PAPR or fitted N-95 mask	1. PAPR or fitted N-95 mask 2. Wash or gel hands (even if gloves used)

Room Cleaning:
After patient is discharged, leave sign posted and door closed for one hour to allow room air to circulate. If unsure, consult facility, engineering or other appropriate department. Then follow facility policy for Airborne Respirator Precautions disinfection and curtain change requirements.

Transport:
Essential transport only. Have patient wear a surgical mask. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

Discontinue precautions as per Facility Policy or Infection Prevention and Control Team

D. **ENHANCED DROPLET PRECAUTIONS**

- For respiratory viruses including COVID-19. Wear N95 or higher-level respirator during aerosolizing procedures. Wear eye protection (face shield or goggles), gown and gloves. Keep door closed.
-

Type and Duration of Precautions - Disease Specific (EKA-~~AKA~~ Short Sheet)

ENHANCED DROPLET PRECAUTIONS

Display sign outside the door. Leave sign posted and door closed for one hour to allow room air to circulate. Environmental Services Personnel removes sign after room is terminally cleaned.

For use with:

- Respiratory viruses including COVID-19

Dishes/utensils:
No special precautions. Kitchenware is sanitized in the dishwasher.

Equipment and Supplies:

- Only essential equipment and supplies in room.
- Use dedicated or disposable equipment when available.
- Avoid use of cellphones.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.

Linen Management:
Follow routine procedures, no special handling required.

Private Room:
If not available, room with patients that have the same organism but no other infection.

Room Cleaning:
Routine cleaning procedures. Disinfect per hospital procedures.

Standard and Tear-away Gown	Three-part Gown
Put ON in this order: <ol style="list-style-type: none"> Wash or gel hands Gown PAPR or N-95 mask Gloves 	Put ON in this order: <ol style="list-style-type: none"> Wash or gel hands Gown PAPR or N-95 mask Gloves
Take OFF & dispose in this order: <ol style="list-style-type: none"> Gloves Gown (outer gown) PAPR or N-95 mask (outside of room) Gown (inner gown) Must wash with soap and water (even if gloves used) Disinfect PAPR hose and battery pack 	Take OFF & dispose in this order: <ol style="list-style-type: none"> Gown and gloves at the same time (grab gown and pull off gloves in one movement) PAPR or N-95 mask (outside of room) Must wash with soap and water (even if gloves used) Disinfect PAPR hose and battery pack

Transport:
Essential transport only. Patient should remain in room except for medical necessity. Patient should wash their hands. Place patient in clean gown. Place surgical mask on patient. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.

~~D.~~

- ~~1. For respiratory viruses including COVID-19. Wear N95 or higher level respirator during aerosolizing procedures. Wear eye protection (face shield or goggles), gown and gloves. Keep door closed.~~

E. **CONTACT ENTERIC PRECAUTIONS**

- ~~1. For conditions including acute diarrhea, C. difficile, Norovirus, and rotavirus. Wash hands with soap and water upon leaving room. Gown and glove at door. Use patient dedicated or disposable equipment. Clean and disinfect shared equipment.~~ For conditions including acute diarrhea, C. difficile, Norovirus, and rotavirus. Wash hands with soap and water upon leaving room. Gown and glove at door. Use patient-dedicated or disposable equipment. Clean and disinfect shared equipment

CONTACT ENTERIC PRECAUTIONS

Display sign outside the door. Remove sign after room is terminally cleaned.

Common Conditions:

- Acute diarrhea
- Clostridioides difficile (C. difficile, C. diff)
- Norovirus
- Rotavirus

Dietary:
Family and visitors should not eat in the room.

Dishes/utensils:
No special precautions. Kitchenware sanitized in dishwasher.

Equipment and Supplies:

- Only essential equipment and supplies in room.
- Use dedicated or disposable equipment when available.
- Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room.
- Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients.

Linen Management:
Bag linen in patient's room.

Personal Protective Equipment:
USE SOAP AND WATER TO WASH HANDS WHEN LEAVING ROOM.

Standard and Tear-away Gown	Three-part Gown
Put ON in this order: <ol style="list-style-type: none"> Wash or gel hands Gown Mask (if needed) Eye cover (if needed) Gloves 	Put ON in this order: <ol style="list-style-type: none"> Wash or gel hands Gown Mask (if needed) Eye cover (if needed) Gloves
Take OFF & dispose in this order: <ol style="list-style-type: none"> Gloves Eye cover (if used) Gown Mask (if used) Must wash with soap and water (even if gloves used) 	Take OFF & dispose in this order: <ol style="list-style-type: none"> Gown and gloves at the same time (grab gown and pull off gloves in one movement) Eye cover (if used) Mask (if used) Must wash with soap and water (even if gloves used)

Private Room:
If not available, please follow facility policy when cohousing patients.

Room Cleaning:
Follow facility policy for Contact Enteric Precautions disinfection and curtain change requirements. **Clean and disinfect with sporicidal-based disinfectant as per facility policy.**

Transport:
Essential transport only. Place patient in clean gown. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.
Discontinue precautions as per Facility Policy or Infection Prevention and Control Team

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

4.

F. **AIRBORNE CONTACT PRECAUTIONS**

- For patients with diarrhea and/or C. difficile. HCW wear N95 mask or PAPR prior to entering room. Keep door closed, **place in Airborne Infection Isolation room required (negative pressure room (C26, 143, 243, 287, 301, 312, 326 387, 443, 487))**. Gown and glove at door. Wash hands with soap and water when entering and leaving room.

AIRBORNE CONTACT PRECAUTIONS							
<p>If patient has diarrhea and/or C.difficile add Contact Enteric Precautions. Display sign outside the door. At patient discharge, remove sign after room is terminally cleaned.</p>							
<p>Common Conditions:</p> <ul style="list-style-type: none"> • Chickenpox • Disseminated herpes zoster (shingles) • Localized zoster in immunocompromised individuals 							
<p>Doctors, Staff, Families, and Visitors enter room only if immune (by history, titer, or immunization) Be certain to educate visitors NOT to enter unless immune – parents and siblings who have not had the disease or immunization may be incubating the disease and be contagious for two days prior to the onset of rash or other symptoms, putting other patients and staff at risk.</p>							
<p>Airborne Infection Isolation Room: Comply with Facility Policy regarding airflow monitoring.</p>							
<p>Dishes/utensils: No special precautions. Kitchenware sanitized in dishwasher.</p>							
<p>Equipment and Supplies:</p> <ul style="list-style-type: none"> • Only essential equipment and supplies in room. • Use dedicated or disposable equipment when available. • Clean and disinfect reusable equipment including intravenous pumps, cell phone or pagers (if used in room), and other electronics, supplies, and other equipment prior to removing from patient's room. • Ensure blood pressure cuff and stethoscope are cleaned and disinfected between patients. 							
<p>Linens Management: Bag linens in patient's room.</p>							
<p>Personal Protective Equipment:</p> <table border="1"> <thead> <tr> <th>Standard and Tear-away Gown</th> <th>Three-part Gown</th> </tr> </thead> <tbody> <tr> <td> <p>Put ON in this order:</p> <ol style="list-style-type: none"> 1. Wash or gel hands 2. Gown 3. Mask (if needed) 4. Eye cover (if needed) 5. Gloves </td> <td> <p>Put ON in this order:</p> <ol style="list-style-type: none"> 1. Wash or gel hands 2. Gown 3. Mask (if needed) 4. Eye cover (if needed) 5. Gloves </td> </tr> <tr> <td> <p>Take OFF & dispose in this order:</p> <ol style="list-style-type: none"> 1. Gloves 2. Eye cover (if used) 3. Gown 4. Mask (if used) 5. Must wash with soap and water (even if gloves used) </td> <td> <p>Take OFF & dispose in this order:</p> <ol style="list-style-type: none"> 1. Gown and gloves at the same time (grab gown and pull off gloves in one movement) 2. Eye cover (if used) 3. Mask (if used) 4. Must wash with soap and water (even if gloves used) </td> </tr> </tbody> </table>		Standard and Tear-away Gown	Three-part Gown	<p>Put ON in this order:</p> <ol style="list-style-type: none"> 1. Wash or gel hands 2. Gown 3. Mask (if needed) 4. Eye cover (if needed) 5. Gloves 	<p>Put ON in this order:</p> <ol style="list-style-type: none"> 1. Wash or gel hands 2. Gown 3. Mask (if needed) 4. Eye cover (if needed) 5. Gloves 	<p>Take OFF & dispose in this order:</p> <ol style="list-style-type: none"> 1. Gloves 2. Eye cover (if used) 3. Gown 4. Mask (if used) 5. Must wash with soap and water (even if gloves used) 	<p>Take OFF & dispose in this order:</p> <ol style="list-style-type: none"> 1. Gown and gloves at the same time (grab gown and pull off gloves in one movement) 2. Eye cover (if used) 3. Mask (if used) 4. Must wash with soap and water (even if gloves used)
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<p>Room Cleaning: Follow facility policy for Airborne Contact Precautions disinfection and curtain change requirements.</p>							
<p>Transport: Essential transport only. Have patient wear a surgical mask. Clean and disinfect transport vehicle. Alert receiving department regarding patient's isolation precaution status.</p>							
<p>Discontinue precautions as per Facility Policy or Infection Prevention and Control Team</p>							

Type and Duration of Precautions Recommended for Selected Infections and Conditions

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Abscess Draining, major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or containment of drainage; until drainage stops or can be contained by dressing
Abscess Draining, minor or limited	Standard		Dressing covers and contains drainage
Acquired human immunodeficiency syndrome (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Actinomycosis	Standard		Not transmitted from person to person
Adenovirus infection (see agent-specific guidance under gastroenteritis, conjunctivitis, pneumonia)			
Amebiasis	Standard		Person to person transmission is rare. Transmission in settings for the mentally challenged and in a family group has been reported [1045]. Use care when handling diapered infants and mentally challenged persons [1046].
Anthrax	Standard		Infected patients do not generally pose a transmission risk.

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Anthrax Cutaneous	Standard		Transmission through non-intact skin contact with draining lesions possible, therefore use Contact Precautions if large amount of uncontained drainage. Handwashing with soap and water preferable to use of waterless alcohol based antiseptics since alcohol does not have sporicidal activity [983].
Anthrax Pulmonary	Standard		Not transmitted from person to person
Anthrax Environmental: aerosolizable spore-containing powder or other substance		Until environment completely decontaminated	Until decontamination of environment complete [203]. Wear respirator (N95 mask or PAPRs), protective clothing; decontaminate persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm)) Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine gluconate after spore contact (alcohol handrubs inactive against spores [983]. Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND
Antibiotic-associated colitis (see <i>Clostridium difficile</i>)			
Arthropod-borne • viral encephalitides (eastern, western, Venezuelan equine encephalomyelitis; St Louis, California encephalitis; West Nile Virus) and • viral fevers (dengue, yellow fever, Colorado tick fever)	Standard		Not transmitted from person to person except rarely by transfusion, and for West Nile virus by organ transplant, breastmilk or transplacentally transplacentally [530, 1047]. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.
Ascariasis	Standard		Not transmitted from person to person
Aspergillosis	Standard		Contact Precautions and Airborne if massive soft tissue infection with copious drainage and repeated irrigations required [154].
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person except rarely by transfusion.
Blastomycosis, North American, cutaneous or pulmonary	Standard		Not transmitted from person to person
Botulism	Standard		Not transmitted from person to person
Bronchiolitis (see respiratory infections in infants and young children)	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.
Brucellosis (undulant, Malta, Mediterranean fever)	Standard		Not transmitted from person to person except rarely via banked spermatozoa and sexual contact [1048, 1049]. Provide antimicrobial prophylaxis following laboratory exposure [1050].


Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
<i>Campylobacter</i> gastroenteritis (see gastroenteritis)			
Candidiasis, all forms including mucocutaneous (with exception of <i>C. auris</i>)	Standard		
Candidiasis (<i>Candida auris</i>)	Contact	Duration of colonization (lifetime of patient)	
Cat-scratch fever (benign inoculation lymphoreticulosis)	Standard		Not transmitted from person to person
Cellulitis	Standard		
Chancroid (soft chancre) (<i>H. ducreyi</i>)	Standard		Transmitted sexually from person to person
Chickenpox (see >varicella)			
<i>Chlamydia trachomatis</i> Conjunctivitis	Standard		
<i>Chlamydia trachomatis</i> Genital (lymphogranuloma venereum)	Standard		
<i>Chlamydia trachomatis</i> Pneumonia (infants ≤3 mos. of age)	Standard		
<i>Chlamydia pneumoniae</i>	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage	Standard		Contact Precautions if there is copious uncontained drainage
Closed-cavity infection No drain or closed drainage system in place	Standard		
<i>Clostridium botulinum</i>	Standard		Not transmitted from person to person
<i>Clostridium difficile</i> (see gastroenteritis, <i>C. difficile</i>)	Contact + Standard	Duration of illness hospital stay	
<i>Clostridium perfringens</i> Food poisoning	Standard		Not transmitted from person to person
<i>Clostridium perfringens</i> Gas gangrene	Standard		Transmission from person to person rare; one outbreak in a surgical setting reported [1053]. Use Contact Precautions if wound drainage is extensive.
Coccidioidomycosis (valley fever) Draining lesions	Standard		Not transmitted from person to person except under extraordinary circumstances because the infectious arthroconidial form of <i>Coccidioides immitis</i> is not produced in humans [1054].
Coccidioidomycosis (valley fever) Pneumonia	Standard		Not transmitted from person to person except under extraordinary circumstances, (e.g., inhalation of aerosolized tissue phase endospores during necropsy, transplantation of infected lung) because the infectious arthroconidial form of <i>Coccidioides immitis</i> is not produced in humans [1054, 1055].
Colorado tick fever	Standard		Not transmitted from person to person
Congenital rubella	Contact + Standard	Until 1 yr of age	Standard Precautions if nasopharyngeal and urine cultures repeatedly neg. after 3 mos. of age


Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial <i>Chlamydia</i>	Standard		
Conjunctivitis Acute bacterial Gonococcal	Standard		
Conjunctivitis Acute viral (acute hemorrhagic)	Contact + Standard	Duration of illness	Adenovirus most common; enterovirus 70 [1056], Coxsackie virus A24 [1057] also associated with community outbreaks. Highly contagious; outbreaks in eye clinics, pediatric and neonatal settings, institutional settings reported. Eye clinics should follow Standard Precautions when handling patients with conjunctivitis. Routine use of infection control measures in the handling of instruments and equipment will prevent the occurrence of outbreaks in this and other settings. [460, 814, 1058, 1059 461, 1060].
Corona virus associated with SARS (SARS-CoV) (see severe acute respiratory syndrome)			
Coxsackie virus disease (see enteroviral infection)			
Creutzfeldt-Jakob disease (CJD, vCJD)	Standard		Use disposable instruments or special sterilization/disinfection for surfaces, objects contaminated with neural tissue if CJD or vCJD suspected and has not been R/O; No special burial procedures [1061]
Croup (see respiratory infections in infants and young children)			
Crimean-Congo Fever (see Viral Hemorrhagic Fever)	Standard		
Cryptococcosis	Standard		Not transmitted from person to person, except rarely via tissue and corneal transplant [1062, 1063]
Cryptosporidiosis (see gastroenteritis)			
Cysticercosis	Standard		Not transmitted from person to person
Cytomegalovirus infection, including in neonates and immunosuppressed patients	Standard		No additional precautions for pregnant HCWs
Decubitus ulcer (see Pressure ulcer)			
Dengue fever	Standard		Not transmitted from person to person
Diarrhea, acute-infective etiology suspected (see gastroenteritis)			
Diphtheria Cutaneous	Contact + Standard	Until off antimicrobial treatment and culture- negative	Until 2 cultures taken 24 hours apart negative
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture- negative	Until 2 cultures taken 24 hours apart negative

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Ebola virus (see viral hemorrhagic fevers)			 Ebola Virus Disease for Healthcare Workers [2014]: Update: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person
Echovirus (see enteroviral infection)			
Encephalitis or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
<i>Enterococcus</i> species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant)			
Enterocolitis, <i>C. difficile</i> (see <i>C. difficile</i> , gastroenteritis)			
Enteroviral infections (i.e., Group A and B Coxsackie viruses and Echo viruses) (excludes polio virus)	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness and to control institutional outbreaks
Epiglottitis, due to <i>Haemophilus influenzae</i> type b	Droplet + Standard	Until 24 hours after initiation of effective therapy	See specific disease agents for epiglottitis due to other etiologies)
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
<i>Escherichia coli</i> gastroenteritis (see gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person
Food poisoning <i>C. perfringens</i> or <i>welchii</i>	Standard		Not transmitted from person to person
Food poisoning Staphylococcal	Standard		Not transmitted from person to person
Furunculosis, staphylococcal	Standard		Contact if drainage not controlled. Follow institutional policies if MRSA
Furunculosis, staphylococcal Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Gangrene (gas gangrene)	Standard		Not transmitted from person to person
Gastroenteritis	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks for gastroenteritis caused by all of the agents below
Gastroenteritis Adenovirus	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis	Standard		Use Contact Precautions for diapered or

Type and Duration of Precautions - Disease Specific (EKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
<i>Campylobacter</i> species			incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Cholera (Vibrio cholerae)</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>C. difficile</i>	Contact + Standard	Duration of illness hospital stay	Discontinue antibiotics if appropriate. Do not share electronic thermometers [853], 854; ensure consistent environmental cleaning and disinfection. Hypochlorite solutions may be required for cleaning if transmission continues [847]. Handwashing with soap and water preferred because of the absence of sporicidal activity of alcohol in waterless antiseptic hand-rubs [983].
Gastroenteritis <i>Cryptosporidium</i> species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>E. coli</i> Enteropathogenic O157:H7 and other shiga toxin-producing strains	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>E. coli</i> Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Giardia lamblia</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Noroviruses	Contact + Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks. Persons who clean areas heavily contaminated with feces or vomitus may benefit from wearing masks since virus can be aerosolized from these body substances [142, 147-148]; ensure consistent environmental cleaning and disinfection with focus on restrooms even when apparently unsoiled [273, 1064]). Hypochlorite solutions may be required when there is continued transmission [290-292]. Alcohol is less active, but there is no evidence that alcohol antiseptic hand rubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks.  Update: The Type of Precaution was updated from “Standard” to “Contact + Standard” to align with <u>Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings (2011)</u>.
Gastroenteritis Rotavirus	Contact + Standard	Duration of illness	Ensure consistent environmental cleaning and disinfection and frequent removal of soiled diapers. Prolonged shedding may occur in both immunocompetent and immunocompromised children and the elderly [932, 933].
Gastroenteritis	Standard		Use Contact Precautions for diapered or

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
<i>Salmonella</i> species (including <i>S. typhi</i>)			incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Shigella</i> species (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Vibrio parahaemolyticus</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis Viral (if not covered elsewhere)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
Gastroenteritis <i>Yersinia enterocolitica</i>	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks
German measles (see rubella; see congenital rubella)			
Giardiasis (see gastroenteritis)			
Gonococcal ophthalmia neonatorum (gonorrhoeal ophthalmia, acute conjunctivitis of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barre' syndrome	Standard		Not an infectious condition
<i>Haemophilus influenzae</i> (see disease-specific recommendations)			
Hand, foot, and mouth disease (see enteroviral infection)			
Hansen's Disease (see Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person
<i>Helicobacter pylori</i>	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine post-exposure as recommended [1065]
Hepatitis, viral Type A-Diapered or incontinent patients	Contact + Standard		Maintain Contact Precautions in infants and children <3 years of age for duration of hospitalization; for children 3-14 yrs. of age for 2 weeks after onset of symptoms; >14 yrs. of age for 1 week after onset of symptoms [833, 1066, 1067].
Hepatitis, viral Type B-HBsAg positive; acute or chronic	Standard		See specific recommendations for care of patients in hemodialysis centers 778
Hepatitis, viral Type C and other unspecified non-A, non-B	Standard		See specific recommendations for care of patients in hemodialysis centers [778]
Hepatitis, viral Type D (seen only with hepatitis B)	Standard		
Hepatitis, viral Type E	Standard		Use Contact Precautions for diapered or incontinent individuals for the duration of illness [1068]
Hepatitis, viral Type G	Standard		



Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Herpangina (see enteroviral infection)			
Hookworm	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Encephalitis	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Mucocutaneous, disseminated or primary, severe	Contact + Standard	Until lesions dry and crusted	
Herpes simplex (<i>Herpesvirus hominis</i>) Mucocutaneous, recurrent (skin, oral, genital)	Standard		
Herpes simplex (<i>Herpesvirus hominis</i>) Neonatal	Contact + Standard	Until lesions dry and crusted	Also, for asymptomatic, exposed infants delivered vaginally or by C-section and if mother has active infection and membranes have been ruptured for more than 4 to 6 hours until infant surface cultures obtained at 24-36 hours. of age negative after 48 hours incubation [1069, 1070]
Herpes zoster (varicella-zoster) (shingles) Disseminated disease in any patient Localized disease in immunocompromised patient until disseminated infection ruled out	Airborne + Contact + Standard	Duration of illness	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for protection of immune HCWs; no recommendation for type of protection, i.e. surgical mask or respirator; for susceptible HCWs.
Herpes zoster (varicella-zoster) (shingles) Localized in patient with intact immune system with lesions that can be contained/covered	Standard	Duration of illness (with wound lesions, until wounds stop draining)	Susceptible HCWs should not provide direct patient care when other immune caregivers are available.
Histoplasmosis	Standard		Not transmitted from person to person
Human immunodeficiency virus (HIV)	Standard		Post-exposure chemoprophylaxis for some blood exposures [866].
Human metapneumovirus	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	HAI reported [1071], but route of transmission not established [823]. Assumed to be Contact transmission as for RSV since the viruses are closely related and have similar clinical manifestations and epidemiology. Wear masks according to Standard Precautions.
Impetigo	Contact + Standard	Until 24 hours after initiation of effective therapy	
Infectious mononucleosis	Standard		
Influenza Human (seasonal Influenza)	-		See Prevention Strategies for Seasonal Influenza in Healthcare Settings (https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm) for current seasonal influenza guidance.
Influenza Avian (e.g., H5N1, H7, H9 strains)	-		See [This link is no longer active: www.cdc.gov/flu/avian/professional/infect-control.htm . Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A

Type and Duration of Precautions - Disease Specific (EKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm), accessed May 2016 March 26, 2025.] for current avian Influenza guidance.
Influenza Pandemic Influenza (also a human Influenza virus)	Droplet		See [This link is no longer active: http://www.pandemicflu.gov . Similar information may be found at Interim Guidance for Infection Control Within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease (https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm), accessed May 2016 March 26, 2025.] for current pandemic Influenza guidance.
Kawasaki syndrome	Standard		Not an infectious condition
Lassa fever (see viral hemorrhagic fevers)	-		
Legionnaires' disease	Standard		Not transmitted from person to person
Leprosy	Standard		
Leptospirosis	Standard		Not transmitted from person to person
Lice Head (pediculosis)	Contact + Standard	Until 24 hours after initiation of effective therapy	See [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016 March 26, 2025.]
Lice Body	Standard		Transmitted person to person through infested clothing. Wear gown and gloves when removing clothing; bag and wash clothes according to CDC guidance [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016 March 26, 2025.]
Lice Pubic	Standard		Transmitted person to person through sexual contact. See CDC's [This link is no longer active: http://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm . Similar information may be found at CDC's Parasites - Lice (https://www.cdc.gov/parasites/lice/index.html), accessed May 2016 March 26, 2025.]
Listeriosis (listeria monocytogenes)	Standard		Person-to-person transmission rare; cross-transmission in neonatal settings reported [1072, 1073 1074, 1075]
Lyme disease	Standard		Not transmitted from person to person
Lymphocytic choriomeningitis	Standard		Not transmitted from person to person
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during patient care 1076-1079. Install screens in windows and doors in endemic areas. Use DEET-containing mosquito repellants and clothing to cover extremities.


Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Marburg virus disease (see viral hemorrhagic fevers)	-		
Measles (rubeola)	Airborne + Standard	4 days after onset of rash; duration of illness (with wound lesions, until wounds stop draining) in immune compromised	<p> Measles Update Interim Measles Infection Control [July 2019 November 2014]:</p> <p> See <u>Interim Infection Prevention and Control Recommendations for Measles in Healthcare Settings (Accessed 3/26/25)</u> Updated recommendations can be found at <u>Immunization of Healthcare Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP)</u> (https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf).</p> <p>Susceptible HCWs should not enter room if immune care providers are available; no recommendation for face protection for immune HCW; no recommendation for type of face protection for susceptible HCWs, i.e., mask or respirator [1027, 1028]. For exposed susceptible susceptible, post-exposure vaccine within 72 hours or immune globulin within 6 days when available [17, 1032, 1034]. Place exposed susceptible patients on Airborne Precautions and exclude susceptible healthcare personnel.</p>
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see enteroviral infections)	Standard		Contact for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates	Standard		
Meningitis Fungal	Standard		
Meningitis <i>Haemophilus Influenzae</i> , type b known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Meningitis <i>Listeria monocytogenes</i> (See Listeriosis)	Standard		
Meningitis <i>Neisseria meningitidis</i> (meningococcal) known or suspected	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease below.
Meningitis <i>Streptococcus pneumoniae</i>	Standard		
Meningitis <i>M. tuberculosis</i>	Standard		Concurrent, active pulmonary disease or draining cutaneous lesions may necessitate addition of Contact and/or Airborne; For children, Airborne Precautions until active tuberculosis ruled out in visiting family members (see tuberculosis below) 42
Meningitis Other diagnosed bacterial	Standard		


Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Meningococcal disease: sepsis, pneumonia, Meningitis	Droplet + Standard	Until 24 hours after initiation of effective therapy	Postexposure chemoprophylaxis for household contacts, HCWs exposed to respiratory secretions; postexposure vaccine only to control outbreaks 15, 17.
<i>Molluscum contagiosum</i>	Standard		
Monkeypox	Airborne + Contact + Standard	Airborne-Until monkeypox confirmed and smallpox excluded Contact-Until lesions crusted	See CDC's Monkeypox website (accessed May 2022) for information on infection prevention and control. See CDC's Monkeypox website (https://www.cdc.gov/poxvirus/monkeypox/) [Current version of this document may differ from original.] for most current recommendations. Transmission in hospital settings unlikely [269]. Pre- and post-exposure smallpox vaccine recommended for exposed HCWs Mpox Infection Prevention and Control in Healthcare Settings Mpox CDC, accessed 3/26/25
Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, Candida auris , ESBLs, resistant <i>S. pneumoniae</i>)	Contact + Standard		MDROs judged by the infection control program, based on local, state, regional, or national recommendations, to be of clinical and epidemiologic significance. Contact Precautions recommended in settings with evidence of ongoing transmission, acute care settings with increased risk for transmission or wounds that cannot be contained by dressings. See recommendations for management options in Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006 (https://www.cdc.gov/infection-control/hcp/mdro-management/?CDC_AAref_Val=https://www.cdc.gov/infectioncontrol/guidelines/mdro/index.html) [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 59 days after the onset of swelling	After onset of swelling; susceptible HCWs should not provide care if immune caregivers are available. Note: (Recent assessment of outbreaks in healthy 18-24 year olds has indicated that salivary viral shedding occurred early in the course of illness and that 5 days of isolation after onset of parotitis may be appropriate in community settings; however the implications for healthcare personnel and high risk patient populations remain to be clarified.)
Mycobacteria, nontuberculosis (atypical)			Not transmitted person-to-person
Mycobacteria, nontuberculosis (atypical) Pulmonary	Standard		
Mycobacteria, nontuberculosis (atypical) Wound	Standard		
<i>Mycoplasma pneumoniae</i>	Droplet + Standard	Duration of Illness	
Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporally [1080-1083].
Nipah virus	See	Duration of	Patient Placement: AIIR

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
 <p>Nipah virus [September 2024] Update: New precaution recommendations for Nipah virus.</p>	<p>comments</p>	<p>precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities. Factors that should be considered include, but are not limited to, presence of symptoms, date symptoms resolved, other conditions that would require specific precautions (e.g. tuberculosis, <i>Clostridium difficile</i>) and available laboratory information.</p>	<p>PPE: If suspect Nipah case and clinically stable: <u>gown, gloves, eye protection, N95® respirator or higher</u> If suspect Nipah and clinically unstable (e.g. hemodynamic instability, vomiting) OR confirmed Nipah case regardless of clinical stability: use <u>PPE according to guidance for confirmed patients and clinically unstable patients suspected to have VHF</u></p>
Nocardiosis, draining lesions, or other presentations	Standard		Not transmitted person-to-person
Norovirus (see gastroenteritis)			
Norwalk agent Gastroenteritis (see gastroenteritis)			
Orf	Standard		
Parainfluenza virus infection, respiratory in infants and young children	Contact + Standard	Duration of illness	Viral shedding may be prolonged in immunosuppressed patients [1009, 1010]. Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Parvovirus B19 (Erythema infectiosum)	Droplet + Standard		Maintain precautions for duration of hospitalization when chronic disease occurs in an immunocompromised patient. For patients with transient aplastic crisis or red-cell crisis, maintain precautions for 7 days. Duration of precautions for immunosuppressed patients with persistently positive PCR not defined, but transmission has occurred [929].
Pediculosis (Lice)	Contact + Standard	Until 24 hours after initiation of effective therapy after treatment	
Pertussis (whooping cough)	Droplet + Standard	Until 5 days after	Single patient room preferred. Cohorting an option. Post-exposure chemoprophylaxis for

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
		initiation of effective antibiotic therapy	household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Current recommendations can be found at <u>Tdap / Td ACIP Vaccine Recommendations</u> (accessed September 2018). <u>ACIP Recommendations: Diphtheria, Tetanus and Pertussis (DTaP/Tdap/Td) Vaccines ACIP Recommendations CDC</u> (accessed 3/26/25)Recommendations for Tdap vaccine in adults under development.  Tdap Vaccine Recommendations [2011] Update: Current recommendations can be found at <u>Tdap / Td ACIP Vaccine Recommendations</u> (www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html).
Pinworm infection (Enterobiasis)	Standard		
Plague (<i>Yersinia pestis</i>) Bubonic	Standard		
Plague (<i>Yersinia pestis</i>) Pneumonic	Droplet + Standard	Until 48 hours after initiation of effective antibiotic therapy	Antimicrobial prophylaxis for exposed HCW [207].
Pneumonia Adenovirus	Droplet + Contact + Standard	Duration of illness	Outbreaks in pediatric and institutional settings reported [376, 1084-1086]. In immunocompromised hosts, extend duration of Droplet and Contact Precautions due to prolonged shedding of virus [931]
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia <i>B. cepacia</i> in patients with CF, including respiratory tract colonization	Contact + Standard	Unknown	Avoid exposure to other persons with CF; private room preferred. Criteria for D/C precautions not established. See CF Foundation guideline [20]
Pneumonia <i>B. cepacia</i> in patients without CF (see multidrug-resistant organisms)			
Pneumonia <i>Chlamydia</i>	Standard		
Pneumonia Fungal	Standard		
Pneumonia <i>Haemophilus influenzae</i> , type b Adults	Standard		
Pneumonia <i>Haemophilus influenzae</i> , type b Infants and children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Pneumonia <i>Legionella spp.</i>	Standard		
Pneumonia	Droplet +	Until 24 hours	See meningococcal disease above

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Meningococcal	Standard	after initiation of effective therapy	
Pneumonia Multidrug-resistant bacterial (see multidrug-resistant organisms)			
Pneumonia <i>Mycoplasma</i> (primary atypical Pneumonia)	Droplet + Standard	Duration of illness	
Pneumonia Pneumococcal pneumonia	Standard		Use Droplet Precautions if evidence of transmission within a patient care unit or facility [196-198, 1087]
Pneumonia <i>Pneumocystis jiroveci</i> (<i>Pneumocystis carinii</i>)	Standard		Avoid placement in the same room with an immunocompromised patient.
Pneumonia <i>Staphylococcus aureus</i>	Standard		For MRSA, see MDROs
Pneumonia Streptococcus, group A Adults	Droplet + Standard	Until 24 hours after initiation of effective therapy	See streptococcal disease (group A streptococcus) below Contact precautions if skin lesions present
Pneumonia <i>Streptococcus</i> , group A Infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	Contact Precautions if skin lesions present
Pneumonia Varicella-zoster (See Varicella- Zoster)			
Pneumonia Viral Adults	Standard		
Pneumonia Viral Infants and young children (see respiratory infectious disease, acute, or specific viral agent)			
Poliomyelitis	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Pressure ulcer (decubitus ulcer, pressure sore) infected Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	If no dressing or containment of drainage; Until drainage stops or can be contained by dressing
Pressure ulcer (decubitus ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage
Prion disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) (<i>Chlamydia psittaci</i>)	Standard		Not transmitted from person to person
Q fever	Standard		

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Rabies	Standard		Person to person transmission rare; transmission via corneal, tissue and organ transplants has been reported [539, 1088]. If patient has bitten another individual or saliva has contaminated an open wound or mucous membrane, wash exposed area thoroughly and administer postexposure prophylaxis. [1089]
Rat-bite fever (<i>Streptobacillus moniliformis</i> disease, <i>Spirillum minus</i> disease)	Standard		Not transmitted from person to person
Relapsing fever	Standard		Not transmitted from person to person
Resistant bacterial infection or colonization (see multidrug-resistant organisms)			
Respiratory infectious disease, acute (if not covered elsewhere) Adults	Standard		
Respiratory infectious disease, acute (if not covered elsewhere) Infants and young children	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Also see syndromes or conditions listed in Table 2
Respiratory syncytial virus infection, in infants, young children and immunocompromised adults	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Wear mask according to Standard Precautions [24] CB [116, 117]. In immunocompromised patients, extend the duration of Contact Precautions due to prolonged shedding [928]). Reliability of antigen testing to determine when to remove patients with prolonged hospitalizations from Contact Precautions uncertain.
Reye's syndrome	Standard		Not an infectious condition
Rheumatic fever	Standard		Not an infectious condition
Rhinovirus	Droplet + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Droplet most important route of transmission [104 1090]. Outbreaks have occurred in NICUs and LTCFs [413, 1091, 1092]. Add Contact Precautions if copious moist secretions and close contact likely to occur (e.g., young infants) [111, 833].
Rickettsial fevers, tickborne (Rocky Mountain spotted fever, tickborne Typhus fever)	Standard		Not transmitted from person to person except through transfusion, rarely
Rickettsialpox (vesicular rickettsiosis)	Standard		Not transmitted from person to person
Ringworm (dermatophytosis, dermatomycosis, tinea)	Standard		Rarely, outbreaks have occurred in healthcare settings, (e.g., NICU [1093], rehabilitation hospital [1094]. Use Contact Precautions for outbreak.
Ritter's disease (staphylococcal scalded skin syndrome)	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below
Rocky Mountain spotted fever	Standard		Not transmitted from person to person except through transfusion, rarely
Roseola infantum (exanthem subitum; caused by HHV-6)	Standard		
Rotavirus infection (see gastroenteritis)			
Rubella (German measles) (also see congenital rubella)	Droplet + Standard	Until 7 days after onset of	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
		rash	wearing face protection (e.g., a surgical mask) if immune. Pregnant women who are not immune should not care for these patients [17, 33]. Administer vaccine within three days of exposure to non-pregnant susceptible individuals. Place exposed susceptible patients on Droplet Precautions; exclude susceptible healthcare personnel from duty from day 5 after first exposure to day 21 after last exposure, regardless of post-exposure vaccine.
Rubeola (see measles)			
Salmonellosis (see gastroenteritis)			
Scabies	Contact	Until 24 hours after initiation of therapy	
Scalded skin syndrome, staphylococcal	Contact	Duration of illness (with wound lesions, until wounds stop draining)	See staphylococcal disease, scalded skin syndrome below)
Schistosomiasis (bilharziasis)	Standard		
Severe acute respiratory syndrome (SARS)	Airborne + Droplet + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining) plus 10 days after resolution of fever, provided respiratory symptoms are absent or improving	Airborne preferred; D if AIIR unavailable. N95 or higher respiratory protection; surgical mask if N95 unavailable; eye protection (goggles, face shield); aerosol-generating procedures and "super shedders" highest risk for transmission via small droplet nuclei and large droplets [93, 94, 96]. Vigilant environmental disinfection (see [This link is no longer active: www.cdc.gov/ncidod/sars . Similar information may be found at CDC Severe Acute Respiratory Syndrome (SARS) (https://www.cdc.gov/sars/index.html), accessed May 2016.]
Shigellosis (see gastroenteritis)			
Smallpox (variola; see Vaccinia for management of vaccinated persons)	Airborne + Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Until all scabs have crusted and separated (3-4 weeks). Non-vaccinated HCWs should not provide care when immune HCWs are available; N95 or higher respiratory protection for susceptible and successfully vaccinated individuals; postexposure vaccine within 4 days of exposure protective [108, 129, 1038-1040].
Sporotrichosis	Standard		
<i>Spirillum minor</i> disease (rat-bite fever)	Standard		Not transmitted from person to person
Staphylococcal disease (<i>S aureus</i>) Skin, wound, or burn Major	Contact	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately Until drainage stops or can be contained by dressing.
Staphylococcal disease (<i>S aureus</i>) Skin, wound, or burn Minor or limited	Standard		If D dressing covers and contains drainage adequately
Staphylococcal disease (<i>S aureus</i>) Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness

Type and Duration of Precautions - Disease Specific (EKA-~~EKA~~ AKA Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Staphylococcal disease (<i>S aureus</i>) Multidrug-resistant (see multidrug-resistant organisms)			
Staphylococcal disease (<i>S aureus</i>) Pneumonia	Standard		
Staphylococcal disease (<i>S aureus</i>) Scalded skin syndrome	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (<i>S aureus</i>) Toxic shock syndrome	Standard		
<i>Streptobacillus moniliformis</i> disease (rat-bite fever)	Standard		Not transmitted from person to person
Streptococcal disease (group A streptococcus) Skin, wound, or burn Major	Contact + Droplet + Standard	Until 24 hours after initiation of effective therapy	No dressing or dressing does not contain drainage adequately Until drainage stops or can be contained by dressing.
Streptococcal disease (group A streptococcus) Skin, wound, or burn Minor or limited	Standard		If D dressing covers and contains drainage adequately
Streptococcal disease (group A streptococcus) Endometritis (puerperal sepsis)	Standard		
Streptococcal disease (group A streptococcus) Pharyngitis in infants and young children	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Pneumonia	Droplet + Standard	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Scarlet fever in infants and young children	Droplet + Standard Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Serious invasive disease	Droplet + Standard Droplet	Until 24 hours after initiation of effective therapy	Outbreaks of serious invasive disease have occurred secondary to transmission among patients and healthcare personnel [162, 972, 1096-1098] Contact Precautions –for draining wound as above; follow rec. for antimicrobial prophylaxis in selected conditions [160].
Streptococcal disease (group B streptococcus), neonatal	Standard		
Streptococcal disease (not group A or B) unless covered elsewhere Multidrug-resistant (see multidrug-resistant organisms)			
Strongyloidiasis	Standard		
Syphilis	Standard		

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Latent (tertiary) and seropositivity without lesions			
Syphilis Skin and mucous membrane, including congenital, primary, secondary	Standard		
Tapeworm disease <i>Hymenolepis nana</i>	Standard		Not transmitted from person to person
Tapeworm disease <i>Taenia solium</i> (pork)	Standard		
Tapeworm disease Other	Standard		
Tetanus	Standard		Not transmitted from person to person
Tinea (e.g., dermatophytosis, dermatomycosis, ringworm)	Standard		Rare episodes of person-to-person transmission
Toxoplasmosis	Standard		Transmission from person to person is rare; vertical transmission from mother to child, transmission through organs and blood transfusion rare
Toxic shock syndrome (staphylococcal disease, streptococcal disease)	Standard		Droplet Precautions for the first 24 hours after implementation of antibiotic therapy if Group A streptococcus is a likely etiology
Trachoma, acute	Standard		
Transmissible spongiform encephalopathy (see Creutzfeldt-Jacob disease, CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (<i>M. tuberculosis</i>) Extrapulmonary, draining lesion	Airborne + Contact + Standard		Discontinue precautions only when patient is improving clinically, and drainage has ceased or there are three consecutive negative cultures of continued drainage [1025, 1026]. Examine for evidence of active pulmonary tuberculosis.
Tuberculosis (<i>M. tuberculosis</i>) Extrapulmonary, no draining lesion, Meningitis	Standard		Examine for evidence of pulmonary tuberculosis. For infants and children, use Airborne until active pulmonary tuberculosis in visiting family members ruled out [42]
Tuberculosis (<i>M. tuberculosis</i>) Pulmonary or laryngeal disease, confirmed	Airborne + Standard		Discontinue precautions only when patient on effective therapy is improving clinically and has three consecutive sputum smears negative for acid-fast bacilli collected on separate days (MMWR 2005; 54: RR-17 Guidelines for Preventing the Transmission of <i>Mycobacterium tuberculosis</i> in Health-Care Settings, 2005 (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e)) [12].
Tuberculosis (<i>M. tuberculosis</i>) Pulmonary or laryngeal disease, suspected	Airborne + Standard		Discontinue precautions only when the likelihood of infectious TB disease is deemed negligible, and either 1. there is another diagnosis that explains the clinical syndrome or 2. the results of three sputum smears for AFB are negative. Each of the three sputum

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen
Tuberculosis (<i>M. tuberculosis</i>) Skin-test positive with no evidence of current active disease	Standard		
Tularemia Draining lesion	Standard		Not transmitted from person to person
Tularemia Pulmonary	Standard		Not transmitted from person to person
Typhoid (<i>Salmonella typhi</i>) fever (see gastroenteritis)			
Typhus <i>Rickettsia prowazekii</i> (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact
Typhus <i>Rickettsia typhi</i>	Standard		Not transmitted from person to person
Urinary tract infection (including pyelonephritis), with or without urinary catheter	Standard		
Vaccinia			Only vaccinated HCWs have contact with active vaccination sites and care for persons with adverse vaccinia events; if unvaccinated, only HCWs without contraindications to vaccine may provide care.
Vaccinia Vaccination site care (including autoinoculated areas)	Standard		Vaccination recommended for vaccinators; for newly vaccinated HCWs: semi-permeable dressing over gauze until scab separates, with dressing change as fluid accumulates, ~3-5 days; gloves, hand hygiene for dressing change; vaccinated HCW or HCW without contraindication to vaccine for dressing changes [205, 221, 225].
Vaccinia (adverse events following vaccination) Eczema vaccinatum	Contact + Standard	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Fetal vaccinia	Contact + Standard Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Generalized vaccinia	Contact + Standard Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact + Standard Contact	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material
Vaccinia (adverse events following vaccination) Post Vaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage



Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infectious condition
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g., <i>S. aureus</i> , group A beta hemolytic streptococcus)	Standard + Contact		Follow organism-specific (strep, staph most frequent) recommendations and consider magnitude of drainage
Varicella Zoster	Airborne + Contact + Standard	Until lesions dry and crusted	Susceptible HCWs should not enter room if immune caregivers are available; no recommendation for face protection of immune HCWs; no recommendation for type of protection, i.e., surgical mask or respirator for susceptible HCWs. In immunocompromised host with varicella Pneumonia, prolong duration of precautions for duration of illness. Post-exposure prophylaxis: provide post-exposure vaccine ASAP but within 120 hours; for susceptible exposed persons for whom vaccine is contraindicated (immunocompromised persons, pregnant women, newborns whose mother's varicella onset is <5days before delivery or within 48 hours after delivery) provide VZIG, when available ASAP post exposure and within 10 days , within 96 hours; if unavailable, use IVIG. Use Airborne for exposed susceptible persons and exclude exposed susceptible healthcare workers beginning 8 days after first exposure until 21 days after last exposure or 28 if received VZIG, regardless of postexposure vaccination. [1036].
Variola (see smallpox)			
<i>Vibrio</i> parahaemolyticus (see gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Marburg, Ebola, Crimean-Congo Hemorrhagic Fever, and South American Hemorrhagic Fever viruses (i.e., those caused by Junin, Machupo, Chapare, Guanarito and Sabia viruses) Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Standard + Droplet + Contact See Comments	Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities. Factors that should be considered include, but are not limited to,	⚠ Guidance on Personal Protective Equipment (PPE) in U.S. Healthcare Settings for: <ul style="list-style-type: none"> <u>Clinically Stable Patients Suspected to have VHF</u> <u>Confirmed Patients and Clinically Unstable Patients Suspected to have VHF</u> <p>Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/healthcare-us/).</p> <p>Single-patient room preferred. Emphasize:</p>

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)


Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
		<p>presence of symptoms, date symptoms resolved, other conditions that would require specific precautions (e.g. tuberculosis, <i>Clostridium difficile</i>) and available laboratory information. Duration of illness (with wound lesions, until wounds stop draining)</p>	<ol style="list-style-type: none"> 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid-resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. <p>Use N95 or higher respirators when performing aerosol-generating procedures. Largest viral load in final stages of illness when hemorrhage may occur; additional PPE, including double gloves, leg and shoe coverings may be used, especially in resource-limited settings where options for cleaning and laundry are limited. Notify public health officials immediately if Ebola is suspected [212, 314, 740, 772]. Also see Table 3 for Ebola as a bioterrorism agent.</p>
Viral respiratory diseases (not covered elsewhere) Adults	Standard		
Viral respiratory diseases (not covered elsewhere) Infants and young children (see respiratory infectious disease, acute)			
Whooping cough (see pertussis)			
Wound infections Major	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	No dressing or dressing does not contain drainage adequately Until drainage stops or can be contained by dressing.
Wound infections Minor or limited	Standard		If d Dressing covers and contains drainage adequately
<i>Yersinia enterocolitica</i> Gastroenteritis (see gastroenteritis)			
Zoster (varicella-zoster) (see herpes zoster)			
Zygomycosis (phycomycosis, mucormycosis)	Standard		Not transmitted person-to-person

Clinical Syndromes or Conditions Warranting Empiric Transmission- Based Precautions in Addition to Standard Precautions

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Diarrhea	Acute diarrhea with a likely infectious cause in an incontinent or diapered patient	Enteric pathogens§	Contact Precautions (pediatrics and adult)
Meningitis	Meningitis	<i>Neisseria meningitidis</i>	Droplet Precautions for first 24 hours of antimicrobial therapy; mask and face protection for intubation
Meningitis	Meningitis	Enteroviruses	Contact Precautions for infants and children
Meningitis	Meningitis	<i>M. tuberculosis</i>	Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general)	<i>Neisseria meningitides</i>	Droplet Precautions for first 24 hours of antimicrobial therapy
Rash or Exanthems, Generalized, Etiology Unknown	Petechial/ecchymotic with fever (general) - If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed. Ebola Virus Disease for Healthcare Workers [2014]  Viral hemorrhagic fevers [September 2024] Update: Precaution recommendations for Viral hemorrhagic fevers have been updated. Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed.  Ebola Virus Disease Update [2014]: Updated recommendations for healthcare workers can be found at Ebola: U.S. Healthcare Workers and Settings (https://www.cdc.gov/vhf/ebola/health-care-us/).
Rash or Exanthems, Generalized, Etiology Unknown	Vesicular	Varicella-zoster, <i>herpes simplex</i> , variola (smallpox), vaccinia viruses	Airborne plus Contact Precautions; Contact Precautions only if Herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely
Rash or Exanthems,	Maculopapular with cough, coryza and	Rubeola (measles) virus	Airborne Precautions

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Disease	Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always Includes Standard Precautions)
Generalized, Etiology Unknown	fever		
Respiratory Infections	Cough/fever/upper lobe pulmonary infiltrate in an HIV- negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in an HIV- infected patient or a patient at high risk for HIV infection	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or MRSA)	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Respiratory Infections	Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza	<i>M. tuberculosis</i> , severe acute respiratory syndrome virus (SARS- CoV), avian influenza	Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.
Respiratory Infections	Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, <i>Human metapneumovirus</i>	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
Skin or Wound Infection	Abscess or draining wound that cannot be covered	<i>Staphylococcus aureus</i> (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected

 **Format Change [February 2017]:** The format of this section was changed to improve readability and accessibility. The content is unchanged.

* Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.

† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g. neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

§ These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella spp*, hepatitis A virus, noroviruses, rotavirus, *C. difficile*.

Infection Control Considerations for High-Priority (CDC Category A) Diseases that May Result from Bioterrorist Attacks or are Considered to be Bioterrorist Threats**Table 3A. Anthrax**

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode Cutaneous and inhalation disease have occurred in past bioterrorist incidents	Cutaneous (contact with spores); Respiratory Tract: (inhalation of spores); Gastrointestinal Tract (ingestion of spores - rare) Comment: Spores can be inhaled into the lower respiratory tract. The infectious dose of <i>B. anthracis</i> in humans by any route is not precisely known. In primates, the LD50 (i.e., the dose required to kill 50% of animals) for an aerosol challenge with <i>B. anthracis</i> is estimated to be 8,000–50,000 spores; the infectious dose may be as low as 1-3 spores
Incubation Period	Cutaneous: 1 to 12 days; Respiratory Tract: Usually 1 to 7 days but up to 43 days reported; Gastrointestinal Tract: 15-72 hours
Clinical Features	Cutaneous: Painless, reddish papule, which develops a central vesicle or bulla in 1-2 days; over next 3-7 days lesion becomes pustular, and then necrotic, with black eschar; extensive surrounding edema. Respiratory Tract: initial flu-like illness for 1-3 days with headache, fever, malaise, cough; by day 4 severe dyspnea and shock, and is usually fatal (85%- 90% if untreated; meningitis in 50% of Respiratory Tract cases. Gastrointestinal Tract: if intestinal form, necrotic, ulcerated edematous lesions develop in intestines with fever, nausea and vomiting, progression to hematemesis and bloody diarrhea; 25-60% fatal
Diagnosis	Cutaneous: Swabs of lesion (under eschar) for immunohistochemistry, polymerase chain reaction and culture; punch biopsy for immunohistochemistry, polymerase chain reaction and culture; vesicular fluid aspirate for Gram stain and culture; blood culture if systemic symptoms; acute and convalescent sera for ELISA serology Respiratory Tract: Chest X-ray or CT scan demonstrating wide mediastinal widening and/or pleural effusion, hilar abnormalities; blood for culture and polymerase chain reaction; pleural effusion for culture, polymerase chain reaction and immunohistochemistry; cerebrospinal fluid if meningeal signs present for immunohistochemistry, polymerase chain reaction and culture; acute and convalescent sera for ELISA serology; pleural and/or bronchial biopsies immunohistochemistry. Gastrointestinal Tract: blood and ascites fluid, stool samples, rectal swabs, and swabs of oropharyngeal lesions if present for culture, polymerase chain reaction and immunohistochemistry.
Infectivity	Cutaneous: Person-to-person transmission from contact with lesion of untreated patient possible, but extremely rare. Respiratory Tract and Gastrointestinal Tract: Person-to-person transmission does not occur. Aerosolized powder, environmental exposures: Highly infectious if aerosolized
Recommended Precautions	Cutaneous: Standard Precautions; Contact Precautions if uncontained copious drainage. Respiratory Tract and Gastrointestinal Tract: Standard Precautions. Aerosolized powder, environmental exposures: Respirator (N95 mask or Powered Air Purifying Respirators), protective clothing; decontamination of persons with powder on them (Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites --- United States, 2001--2002 (https://www.cdc.gov/mmwr/preview/mmwrhtml/mm5135a3.htm)). Hand hygiene: Handwashing for 30-60 seconds with soap and water or 2% chlorhexidine chlorhexidine gluconate after spore contact (alcohol hand rubs inactive against spores [Weber DJ JAMA 2003; 289:1274]). Post-exposure prophylaxis following environmental exposure: 60 days of antimicrobials (either doxycycline, ciprofloxacin, or levofloxacin) and post-exposure vaccine under IND

Table 3B. Botulism

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Gastrointestinal Tract: Ingestion of toxin-containing food, Respiratory Tract: Inhalation of toxin containing aerosol cause disease. Comment: Toxin ingested or potentially delivered by aerosol in bioterrorist incidents. LD50 (lethal dose for 50% of experimental animals) for type A is 0.001 µg/ml/kg.
Incubation Period	1-5 days.
Clinical Features	Ptosis, generalized weakness, dizziness, dry mouth and throat, blurred vision, diplopia, dysarthria, dysphonia, and dysphagia followed by symmetrical descending paralysis and respiratory failure.
Diagnosis	Clinical diagnosis; identification of toxin in stool, serology unless toxin-containing material available for toxin neutralization bioassays.
Infectivity	Not transmitted from person to person. Exposure to toxin necessary for disease.
Recommended Precautions	Standard Precautions.

Table 3C. Ebola Hemorrhagic Fever

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	As a rule infection develops after exposure of mucous membranes or respiratory tract, or through broken skin or percutaneous injury.
Incubation Period	2-19 days, usually 5-10 days
Clinical Features	Febrile illnesses with malaise, myalgias, headache, vomiting and diarrhea that are rapidly complicated by hypotension, shock, and hemorrhagic features. Massive hemorrhage in < 50% pts.
Diagnosis	Etiologic diagnosis can be made using respiratory tract-polymerase chain reaction, serologic detection of antibody and antigen, pathologic assessment with immunohistochemistry and viral culture with EM confirmation of morphology.
Infectivity	Person-to-person transmission primarily occurs through unprotected contact with blood and body fluids; percutaneous injuries (e.g., needlestick) associated with a high rate of transmission; transmission in healthcare settings has been reported but is prevented by use of barrier precautions.
Recommended Precautions	Hemorrhagic fever specific barrier precautions: If disease is believed to be related to intentional release of a bioweapon, epidemiology of transmission is unpredictable pending observation of disease transmission. Until the nature of the pathogen is understood and its transmission pattern confirmed, Standard, Contact and Airborne Precautions should be used. Once the pathogen is characterized, if the epidemiology of transmission is consistent with natural disease, Droplet Precautions can be substituted for Airborne Precautions. Emphasize: <ol style="list-style-type: none"> 1. use of sharps safety devices and safe work practices, 2. hand hygiene; 3. barrier protection against blood and body fluids upon entry into room (single gloves and fluid- resistant or impermeable gown, face/eye protection with masks, goggles or face shields); and 4. appropriate waste handling. Use N95 or higher respirators when performing aerosol-generating procedures. In settings where AIIRs are unavailable or the large numbers of patients cannot be accommodated by existing AIIRs, observe Droplet Precautions (plus Standard Precautions and Contact Precautions) and segregate patients from those not suspected of VHF infection. Limit blood draws to those essential to care. See text for discussion and Appendix A for recommendations for naturally occurring VHFs.

Plague

Pneumonic plague is not as contagious as is often thought. Historical accounts and contemporary evidence indicate that persons with plague usually transmit the infection only when the disease is in the end stage. These persons cough copious amounts of bloody sputum that contains many plague bacteria. Patients in the early stage of primary pneumonic plague (approximately the first 20–24 h) apparently pose little risk [1, 2]. Antibiotic medication rapidly clears the sputum of plague bacilli, so that a patient generally is not infective within hours after initiation of effective antibiotic treatment [3]. This means that in modern times many patients will never reach a stage where they pose a significant risk to others. Even in the end stage of disease, transmission only occurs after close contact. Simple protective measures, such as wearing masks, good hygiene, and avoiding close contact, have been effective to interrupt transmission during many pneumonic plague outbreaks [2]. In the United States, the last known cases of person to person transmission of pneumonic plague occurred in 1925 [2].

Table 3D. Plague

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract: Inhalation of respiratory droplets. Comment: Pneumonic plague most likely to occur if used as a biological weapon, but some cases of bubonic and primary septicemia may also occur. Infective dose 100 to 500 bacteria
Incubation Period	1 to 6, usually 2 to 3 days.
Clinical Features	Pneumonic: fever, chills, headache, cough, dyspnea, rapid progression of weakness, and in a later stage hemoptysis, circulatory collapse, and bleeding diathesis
Diagnosis	Presumptive diagnosis from Gram stain or Wayson stain of sputum, blood, or lymph node aspirate; definitive diagnosis from cultures of same material, or paired acute/convalescent serology.
Infectivity	Person-to-person transmission occurs via respiratory droplets risk of transmission is low during first 20-24 hours of illness and requires close contact. Respiratory secretions probably are not infectious within a few hours after initiation of appropriate therapy.
Recommended Precautions	Standard Precautions, Droplet Precautions until patients have received 48 hours of appropriate therapy. Chemoprophylaxis: Consider antibiotic prophylaxis for HCWs with close contact exposure.

1. Wu L-T. A treatise on pneumonic plague. Geneva: League of Nations, 1926. III. Health.
2. Kool JL. Risk of person to person transmission of pneumonic plague. *Clinical Infectious Diseases*, 2005; 40 (8): 1166-1172
3. Butler TC. Plague and other Yersinia infections. In: Greenough WB, ed. *Current topics in infectious disease*. New York: Plenum Medical Book Company, 1983.

Table 3E. Smallpox

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	Respiratory Tract Inhalation of droplet or, rarely, aerosols; and skin lesions (contact with virus). Comment: If used as a biological weapon, natural disease, which has not occurred since 1977, will likely result.
Incubation Period	7 to 19 days (mean 12 days)
Clinical Features	Fever, malaise, backache, headache, and often vomiting for 2-3 days; then generalized papular or maculopapular rash (more on face and extremities), which becomes vesicular (on day 4 or 5) and then pustular; lesions all in same stage.
Diagnosis	Electron microscopy of vesicular fluid or culture of vesicular fluid by WHO approved laboratory (CDC); detection by polymerase chain reaction available only in select LRN labs, CDC and USAMRID
Infectivity	Secondary attack rates up to 50% in unvaccinated persons; infected persons may transmit disease from time rash appears until all lesions have crusted over (about 3 weeks);

Type and Duration of Precautions - Disease Specific (FKA-~~AKA~~ Short Sheet)

Characteristics	Infection Control Considerations
	greatest infectivity during first 10 days of rash.
Recommended Precautions	<p>Combined use of Standard, Contact, and Airborne Precautions until all scabs have separated (3-4 weeks). Transmission by the airborne route is a rare event; Airborne Precautions is recommended when possible, but in the event of mass exposures, barrier precautions and containment within a designated area are most important. 204, 212</p> <p>Only immune HCWs to care for pts; post-exposure vaccine within 4 days. Vaccinia: HCWs cover vaccination site with gauze and semi-permeable dressing until scab separates (≥21 days). Observe hand hygiene.</p> <p>Adverse events with virus-containing lesions: Standard plus Contact Precautions until all lesions crusted.</p> <p>Vaccinia adverse events with lesions containing infectious virus include inadvertent autoinoculation, ocular lesions (blepharitis, conjunctivitis), -generalized vaccinia, progressive vaccinia, eczema vaccinatum; bacterial superinfection also requires addition of contact precautions if exudates cannot be contained. 216, 217</p>

Table 3F. Tularemia

Characteristics	Infection Control Considerations
Site(s) of Infection; Transmission Mode	<p>Respiratory Tract: Inhalation of aerosolized bacteria.</p> <p>Gastrointestinal Tract: Ingestion of food or drink contaminated with aerosolized bacteria.</p> <p>Comment: Pneumonic or typhoidal disease likely to occur after bioterrorist event using aerosol delivery. Infective dose 10-50 bacteria</p>
Incubation Period	2 to 10 days, usually 3 to 5 days
Clinical Features	<p>Pneumonic: malaise, cough, sputum production, dyspnea;</p> <p>Typhoidal: fever, prostration, weight loss and frequently an associated pneumonia.</p>
Diagnosis	Diagnosis usually made with serology on acute and convalescent serum specimens; bacterium can be detected by polymerase chain reaction (LRN) or isolated from blood and other body fluids on cysteine-enriched media or mouse inoculation.
Infectivity	<p>Person-to-person spread is rare.</p> <p>Laboratory workers who encounter/handle cultures of this organism are at high risk for disease if exposed.</p>
Recommended Precautions	Standard Precautions

infectio

Recommendations for Application of Standard Precautions for the Care of All Patients in All Healthcare Settings

Component	Recommendations
Hand hygiene	After touching blood, body fluids, secretions, excretions, contaminated items; immediately after removing gloves; between patient contacts.
Personal protective equipment (PPE) Gloves	For touching blood, body fluids, secretions, excretions, contaminated items; for touching mucous membranes and nonintact skin
Personal protective equipment (PPE) Gown	During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.
Personal protective equipment (PPE) Mask, eye protection (goggles), face shield	During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection.
Soiled patient-care equipment	Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene.
Environmental control	Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.
Textiles and laundry	Handle in a manner that prevents transfer of microorganisms to others and to the environment
Needles and other sharps	Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only; use safety features when available; place used sharps in puncture-resistant container
Patient resuscitation	Use mouthpiece, resuscitation bag, other ventilation devices to prevent contact with mouth and oral secretions
Patient placement	Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.
Respiratory hygiene/cough etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)	Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

(See Sections II.D.-II.J. and III.A.1)

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 11/99 SUBJECT: Communication of Results –
Women's Center

REVISION DATE: 08/11, 02/19, 02/23, 03/25

Mammography Department Approval: ~~11/24~~10/25
Department of Radiology Approval: ~~02/25~~12/25
Pharmacy & Therapeutics Committee Approval: n/a
Medical Executive Committee Approval: ~~02/25~~01/26
Administration Approval: ~~03/25~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/25

A. **AUTHORIZED TO PERFORM:**

1. Radiologists and Records Techs

B. **PURPOSE:**

1. To meet Mammography Quality Standard Act (MQSA) standards to ensure that reports/results are sent to patients and referring physicians in a timely way.

C. **POLICY:**

1. The Mammography Center will provide patients with written results within thirty (30) days. Self-referring patients will receive the written report as well as the summary.
2. MQSA responsible technologist follows up FDA regulations according to title 17 mammography notification policy to assure all patients will receive layout summary report notification letters to their mailing addresses. If there is any returned mail due to incorrect mailing address, there is a procedure in place:
 - a. MQSA responsible person will contact the patient to confirm the correct address.
 - b. Correct address will be replaced and revised in patients' file by registration.
 - c. Letter will be mailed to the patient with the new corrected address.
 - d. Patients who have not been accessed due to an incorrect contact number, MQSA responsible person will contact patient's ~~MD~~ **referring physician office as soon as possible.** ~~office to notify them ASAP.~~
3. Results that are "suspicious" or "highly suggestive of malignancy" will be communicated directly by the interpreting Radiologist or designee ~~ASAP~~ **as soon as possible** to the referring MD; the mammography report is provided to the healthcare provider and the patient lay summary is provided to the patient within 7 calendar days of the date the mammogram was interpreted.
4. ~~or, if self-referred~~, to the patient. Self referred patients will be given the Breast Help Line phone number, **760**—940-5100, for a list of physicians for follow-up.
5. Patients that are called back to the facility for additional views will be scheduled within ten (10) working days. The department's scheduler will make several attempts to contact the patient. If the patient cannot be reached, a letter will be sent to the referring physician reporting our request for follow-up. If the mammography department receives no response within seven (7) working days, a certified letter will be sent to the patient's residence signifying the importance of breast imaging follow-up. A copy of receipt of letter will be filed with the patient's records.
6. When the exam has an assessment of "incomplete: Need prior mammograms for comparison", the facility ~~will~~ issued a follow-up report with a final overall assessment within

30 calendar days of the initial report, regardless of whether comparison views are obtained.

D. **EXTERNAL LINK(S):**

1. Mammography Quality Standards Act (MQSA) of 1998
<https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf>
2. Mammography Clinical Experience Requirements (2017) <https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4>

E. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from <https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm>
3. <https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-and-program>.
4. CALIFORNIA CODE OF REGULATIONS TITLE 17. PUBLIC HEALTH
PAGE 202.13
30317.60. MEDICAL OUTCOMES AUDIT
SECTION 30319.20

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 10/97 **SUBJECT:** ~~Completion of Diagnostic Report~~
Diagnostic Mammogram

REVISION DATE: 08/11, 02/19, 02/23

Mammography Department Approval:	09/24 10/25
Department of Radiology Approval:	10/18 12/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	01/23 01/26
Administration Approval:	02/23 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. RESPONSIBILITY:

- ~~Transcriptionists, Radiology Records Techs~~
Certified Mammogram technologist and Interpreting physician

B. PURPOSE:

- To expedite the finalization of the diagnostic report.

C. POLICY:

- The diagnostic report will be dictated, finalized, ~~transcribed, printed,~~ and distributed to the referring physicians in a timely manner.

D. PROCEDURE:

- ~~The transcription department will transcribe~~ Radiologists will transcribe the diagnostic mammogram and reports will be submitted to the referring physician ~~in a timely manner~~ within 24-48 hours.
- Patients will be contacted from scheduling department for follow up diagnostic imaging recommendations according to radiologist recommendation on the finalized reports.
- All diagnostic mammogram procedures will be followed up through medical audit procedure.
- Notification letters will be submitted to the patients after the diagnostic mammogram has finalized and reported to the referring physician.
- ~~The Radiologist will review the report and make corrections.~~
- ~~The Radiologist will finalize the report.~~
- ~~Periodically, throughout the day, the signed reports are printed for distribution.~~

E. REFERENCE(S):

- ARRT(2017, JULY 1) Updated Mammography Content Specifications, Clinical Experience Requirements, and Task Inventory, Retrieved from <http://www.aart.org/news/2017/-3/22/updated-mammography-content-specifications-clinical-experience-requirements-and-task-inventory-effective-july-1-2017>
- Mammography Quality Standards Act (MQSA) and MQSA Program

<https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf>

F. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	06/93	SUBJECT:	Mammography Image/Data Retention, Check-Out and Copying
REVISION DATE:	08/11, 01/19, 02/23		
Mammography Department Approval:	09/24 10/25		
Department of Radiology Approval:	10/24 12/25		
Pharmacy & Therapeutics Committee Approval:	n/a		
Medical Executive Committee Approval:	01/23 01/26		
Administration Approval:	02/23 02/26		
Professional Affairs Committee Approval:	n/a		
Board of Directors Approval:	02/23		

A. AUTHORIZED TO PERFORM:

1. Radiology records technician, radiologic technologist.

B. PURPOSE:

1. To ensure that all original films and reports are retained in accordance with Joint Commission (JC) and hospital policies; to ensure that all appropriate requests for films and/or reports are handled in the proper manner to maintain patient confidentiality and legal requirements.

C. POLICY:

1. All employees are responsible to maintain the files, films, and reports in good order.

D. PROCEDURE:

1. Retention:
 - a. Images and reports are filed by the Imaging Services Department using the patient's medical record number and a terminal digit and most recent year of visit.
 - b. All images/data and reports are retained for ten (5) years by the Imaging Department.
 - i. Films on all minors (under age 18) are retained until 25 years of age.
 - ii. Mammographs are retained 10 years or 5 years if a new set of images are performed at the facility

E. REQUEST COPY OF REPORTS/MAMMOGRAMS/ULTRASOUND:

1. Requests for copies of report/images on a disc should be directed to the Film Library.
2. Requests by patients:
 - a. Patients may check out their original reports/mammograms only if they complete the authorization form for disclosure of individually identifiable health information, as set forth and consistent with California and Federal law concerning the privacy of such information.
 - b. Patients need to fill out the Authorization for Use or Disclosure form and sign the form by presenting their identification documents.
3. Requests by Mammography from outside facilities:
 - a. Women's Diagnostic Center may request a copy of reports/mammograms/ultrasounds through Medical Record Department Fax Transmittal Sheet.
 - b. Patient needs to sign and fill out the authorization form to authorize the release of medical records, mammograms and reports to Tri-City Medical Center Women's Diagnostic Center.

- c. Mammographer needs to send the release of authorization request by finding the fax number from Mammography Centers Directory.
- d. Transfer of Digital mammograms or digital breast tomosynthesis, or release of copies, take place within 10-15 calendar days of receiving the request;
- e. Radiology Medical Records will provide original digital images electronically by NUCLEUS/IMAGE SHARING or through a CD released through TCMC authorization process, along with a facsimile of the report. (21 CFR 900.12©(4)(iii), (v)).

F. **FACSIMILE TRANSMISSION (FAX):**

1. In accordance with Administrative Compliance Policy: Faxing Protected Health Information 522, confidentiality of all patient records must be maintained at all times, and is not to be discussed with any person not directly associated with the case.
2. Facsimile machines may be used to transmit confidential information (e.g., reports), but reasonable care must be taken to assure the information reaches its destination (e.g., confirmation form) and is kept confidential.
3. Per Administrative Information Technology Policy: Fax Transmissions 616 a FAX transmittal sheet must accompany any records that are sent via facsimile machine and maintained as a permanent part of the patient's file.

G. **DISCIPLINARY ACTION:**

1. Failure to follow these guidelines for film retention and release will result in disciplinary action.

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

1. Administrative Compliance Policy: Faxing Protected Health Information 8610-522
2. Administrative Compliance Policy: Patient Access to Protected Health Information in the Designated Record Set 8610-516
3. Administrative Information Technology Policy: Fax Transmissions 8610-616

I. **REFERENCE(S):**

1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from <https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm>

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	12/99	SUBJECT:	Mammography Quality Assurance (QA) Plan
REVISION DATE:	08/11, 01/19, 02/23		
Mammography Department Approval:	09/24	10/25	
Department of Radiology Approval:	10/24	12/25	
Pharmacy & Therapeutics Committee Approval:	n/a		
Medical Executive Committee Approval:	01/23	01/26	
Administration Approval:	02/23	02/26	
Professional Affairs Committee Approval:	n/a		
Board of Directors Approval:	02/23		

A. PURPOSE:

1. To ensure the safety, reliability, clarity and accuracy of mammography services performed at Tri-City Medical Center (TCMC).

B. POLICY:

1. The Edgar and JoAnne Jones Mammography Quality Assurance Program will meet the Mammography Quality Standard Act (MQSA) standards and those of other appropriate regulatory bodies. The program will be reviewed bi-annually by the responsible mammography interpreting physician as mandated by California Code of Regulations, Title 17, Section 30317.20. The program will consist of multiple parts and be supported by a system that incorporates the following:
 - a. Audit of Results
 - i. Whereby positive results are entered into the system
 - ii. System in place to obtain all pathology results
 - iii. System in place to compare pathology results with physician interpretations
 - iv. Analysis data kept for at least 24 months following the analysis
 - b. Reporting of Results - communication of results to patients and physicians.
 - c. Appropriate procedures to ensure consistency and safety in performance and procedures.
 - d. Defined processes/responsibilities to support the service
 - e. Monitoring of important aspects of care
 - f. Patient satisfaction data
 - g. Competent staff - orientation, training, and continuing education
 - h. Equipment - Quality Control testing and corrective actions followed up when results not acceptable
 - i. Annual Medical Physicians Survey performed in a timely and complete manner, with results and recommendation reviewed by the facility
 - j. Performance improvement

C. RESPONSIBILITIES :

1. Responsible individuals shall:
 - a. Be qualified for assignments.
 - b. Know the specifics of their assigned tasks.
 - c. Have adequate time to perform duties.

D. EXTERNAL LINK(S):

1. Mammography Quality Standards Act (MQSA) of 1998
<https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf>

E. **REFERENCE(S):**

1. California Code of Regulations, Title 17, Section 30317.20
2. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).

9. ~~. complete an "Additional Evaluation Required" form, which constitutes a diagnostic order from physician.~~
10. ~~If a breast abnormality is identified on the same date of service prior to the patient leaving, and additional films are performed, the patient's screening mammogram will be edited by the technologist to a diagnostic mammogram as per Radiologist's orders.~~
11. ~~If this breast abnormality is identified after the patient has left our facility, the patient will be billed for the screening mammogram on the original date of service and will be billed for a diagnostic mammogram on the return visit.~~
12. ~~One copy of this order will be given to the registrar in the Women's Diagnostic Center and a second copy to the Billing Department.~~

E. **EXTERNAL LINK(S):**

1. Mammography Clinical Experience Requirements (2017) <https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4>

F. **REFERENCE(S):**

1. ~~AART~~ ARRT (2017, July 1) Updated Mammography Content Specifications, Clinical Experience Requirements, and Task Inventory. Retrieved from <https://www.arrt.org/news/2017/03/22/updated-mammography-content-specifications-clinical-experience-requirements-and-task-inventory-effective-july-1-2017>

- physician necessary to stabilize that emergency medical condition, within the capability of this facility Tri-City Medical Center (TCMC). A triage nurse exam is not a medical screening exam.
- b. An MSE is required on all patients who present to the ED/hospital campus with a medical complaint.
 - c. A request for an MSE will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, the individual needs an examination or treatment for a medical condition.
 - d. The MSE is an ongoing process, not an isolated event.
5. Capacity:
- a. The ability of the hospital to accommodate the individual requesting examination or treatment. In certain circumstances (e.g., redirecting an individual to an alternate location for a MSE pursuant to an emergency preparedness plan, or a transfer as necessitated in the instance of a declared emergency), the hospital may be eligible to request a waiver.
 - b. Includes the hospitals past practices of accommodating patients in excess of occupancy limits.
6. Stable:
- a. Stable for Transfer:
 - i. With respect to an emergency medical condition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during the transfer of the individual from a facility, or that the woman has delivered the child or placenta. A patient will be deemed stabilized if the treating physician attending the patient in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.
 - b. For transfer between facilities:
 - i. A patient is stable for transfer if the patient is transferred from one facility and the treating physician attending to the patient has determined, within reasonable clinical confidence, that the patient is expected to leave the hospital and be received at the second facility, with no material deterioration in his/her medical condition; and the treating physician reasonably believes the receiving facility has the capability to manage the patient's medical condition, and any reasonably foreseeable complication of that condition.
 - ii. If the patient is determined by the treating physician to require a higher level of care than can be provided at TCMC, the transfer can be accomplished by mutual agreement between the sending and receiving physicians. This may be accomplished even if the patient is "unstable," if the physicians determine that the benefits of the transfer outweigh the risks.
 - iii. Transfers should only be made in the following circumstances:
 - 1) For care that exceeds the capabilities of the transferring hospital.
 - 2) Upon patient request.
 - c. Stable for Discharge:
 - i. Means the treating physician has determined within reasonable clinical confidence that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, may be reasonably performed on an outpatient basis or a later inpatient basis, and the patient has been given a plan for appropriate follow-up care with the discharge instructions.
 - ii. The emergency medical condition that caused the individual to seek care in the Emergency Department must be resolved (although the underlying medical condition may persist).
 - d. Psychiatric Patients Stable for Transfer:

- i. A psychiatric patient is considered stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is considered stable when he/she is no longer considered an imminent threat to himself/herself or to others.
 - ii. Psychiatric patients who are being transferred on a psychiatric hold will be placed in restraints, solely for the duration of the transfer, in order to minimize the risk of elopement.
 - e. Stable for transfer or Stable for Discharge: Does not require the final resolution of the emergency medical condition.
- 7. Inpatient:
 - a. A person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services.
- 8. Outpatient:
 - a. A person who has come to a hospital outpatient department for the purposes of keeping a previously scheduled appointment. This shall include any patient presenting to the ED with a medical complaint.

C. **GUIDELINES:**

1. The goal is every ED patient will be seen by a physician or physician assistant within 30 minutes after the patient is placed in a bed and assessed by a nurse; this should occur in the majority of cases.
2. The appropriate on-call physician will be called when the Emergency Medicine physician:
 - a. Does not have the expertise or capability to treat the EMC; or,
 - b. Needs the on-call physician to stabilize the patient in the ED; or,
 - c. Needs the on-call physician to admit the patient for further stabilizing treatment; or,
 - d. Needs the on-call physician to help stabilize the patient in the ED prior to transfer to a tertiary facility, or another acute care facility.
 - e. Requires assistance of the on-call physician to determine if an EMC exists.
3. The on-call physician is expected to respond telephonically to the Emergency Department within 30 minutes for STAT calls, and within 60 minutes for routine calls. The on call physician will come to the Emergency Department to see the patient if the Emergency Medicine physician determines it is necessary, and within the timeframe reasonably determined by the Emergency Department physician. In any event, the on-call physician must be able to respond in person to the Emergency Department within 30 minutes of the request to respond in person.
 - a. If, after consulting with the ED physician, an on-call physician recommends that a patient be transferred to an outside hospital for a higher level of care, the on-call physician will evaluate the patient in the ED within a timeframe reasonable determined by the Emergency Medicine Physician, but no longer than 4-hours after the transfer recommendation is made. If a recommended transfer is delayed more than 24 hours for any reason, the on-call physician or their designated coverage will continue to round on the patient in the ED as frequently as necessary (but no less frequently than every 24-hours) until the transfer is accomplished. The on-call physician or their designated coverage shall also remain available for the duration of the transfer process to consult with the accepting physician(s) at the receiving hospital regarding the need for transfer.
4. If the personal physician is treating his/her patient in the ED, that physician is expected to see the patient in the ED, or consult by telephone with the Emergency Medicine physician within 30 minutes of being notified the patient is in the ED, and see the patient in the ED less than 60 minutes after notification the patient is in the ED.
 - a. If the on-call physician or a personal physician meets the patient in the ED, that physician's evaluation of the patient constitutes the MSE. The examination, the treatment, and the documentation of the encounter must comply with EMTALA exactly as if the Emergency Medicine physician were caring for the patient. The on-call or personal physician shall inform the Emergency Medicine Physician of the MSE.

- b. If a personal physician wishes to see their patient in the ED, but is unable to respond within 60 minutes, or if the Emergency physician or ED nurse feels the patient is potentially unstable, the MSE will be performed by the Emergency Medicine physician.
5. A patient will not be sent to the on-call (or personal) physician's office for an examination or treatment, unless deemed stable, and appropriate by the Emergency Medicine physician. Notwithstanding the above, if specialized equipment exists in the practitioner's office, which would be necessary for care, the on-call physician may confer with the Emergency Medicine physician to determine if further treatment in the office would be safe for the patient, and beneficial for care.
6. With regard to ED patients and inpatients, the physician on the ED call panel at the time consultant/specialist/surgical services are needed is the physician responsible for ensuring the related needs of the patient are met during that service encounter/admission.
 - a. If a patient presents to the ED with an Emergency Medical Condition and the on-call specialist is unavailable, the Emergency Medicine Physician will proceed as defined in section C.12 below.
7. Duties Of The On-Call Physician:
 - a. Respond to the ED to medically screen and/or stabilize emergency patients.
 - b. Respond to inpatient unit of the hospital to stabilize patients as requested. The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. See required timeframes under "duties of the on-call physician to inpatients" below.
 - c. Accept transferred patients from other hospitals, with an emergency medical condition on behalf of the hospital, if the hospital can provide the requested care for an emergency medical condition, and the transferring facility cannot provide this care, the hospital/on-call physician is obliged to accept the transfer.
 - d. Report suspected EMTALA violations by other hospitals to the hospital's legal counsel, and provides the necessary documentation.
8. Duties of the On-Call Physician to Inpatients:
 - a. Any member of the Medical Staff may request the services of the on-call physician to help stabilize and manage an inpatient in accordance with acceptable standards. All such requests shall indicate it is an urgent/emergent request (requiring a 30 minute telephone response) or non-emergent/urgent (requiring a 2-hour telephone response). The in-person consultation must be completed by the on-call physician or designated alternate within a clinically appropriate time frame, and not to exceed **24-48**-hours of request.
9. Insurance Status:
 - a. The hospital's normal registration process may be followed so long as a screening or stabilizing treatment is not delayed. The process may include discussion of insurance or payment obligations.
 - b. The hospital will not require authorization from an individual's insurance company before providing a screening, or initiating any necessary stabilizing treatment.
10. Mechanisms for maintaining the call roster:
 - a. The rules and regulations of each applicable Department/Division will address credentials, and qualifications regarding on-call services.
 - b. The Emergency Department Roster for each specialty will:
 - i. Be submitted to the Medical Staff Office at least two weeks in advance of the first day of the month.
 - ii. Include the full month of coverage.
 - iii. List a specific physician's name for each day on call:
 1. Every physician listed must be a member of the Medical Staff at TCMC, and a member of the Department/Division responsible for the specialty's emergency coverage.

- c. Each on-call physician is solely responsible for arranging trades or temporary coverage of on-call duties. The on-call physician must notify the ED and the Medical Staff Office of any changes in advance.
 - d. The Medical Staff Office will provide the ED on-call schedule to each physician who is taking call during the month.
 - e. The Medical Staff Office will provide the ED on-call schedule to the ED and the TCMC Operators prior to the schedule starting.
11. Dispute Resolution:
- a. If an on-call physician disagrees with the Emergency Medicine physician about the need to come to the ED, he/she must still come to the ED to examine and treat the patient.
 - b. The appropriateness of the Emergency Medicine physician's request for assistance can be reviewed through the regular Medical Staff processes after the patient has been treated (see Sections C.13 and 14).
12. Lack of Timely Response or refusal of the on-call to respond or unexpected lapses in on-call coverage:
- a. If the Emergency Medicine physician or any member of the Medical Staff pursuant to item #8 above determines the patient requires the services of a physician listed by the hospital on its roster of on-call physicians, and if after being notified, the on-call physician fails or refuses to respond as described above, the Division Chief or Department Chair for the requested specialty shall be contacted to enforce the on-call obligation, or designate an alternative. A Quality Review Report (QRR) shall be completed regarding the failure/lack of timely response by the on-call physician, and submitted to Risk, Legal and Regulatory Services, and the Medical Staff Office for follow-up.
 - b. If the failure/lack of timely response results in the Emergency Medicine physician ordering the transfer of the individual because without the services of the on-call physician the benefits of the transfer outweigh the risks of transfer; the Emergency Medicine physician responsible for transfer shall provide the name and address of the on-call physician to the receiving medical facility at the time of transfer. A QRR shall be completed for this event as well and submitted to Risk, Legal and Regulatory Services, and the Medical Staff Office for follow-up.
 - c. In the event the on-call physician is unavailable as he/she is otherwise detained providing medical care, the on-call physician or his/her designee should inform the Emergency Medicine physician of the status of his/her availability. The Division Chief or Department Chair (for the requested specialty) shall be contacted to designate an alternative specialist to respond. If an alternative specialist is not available, the hospital's transfer policy will be invoked.
13. Disciplinary proceedings for failure to comply:
- a. Any QRR received due to failure to comply, will be referred to the respective Department Chair/Division Chief, or designee for review and consideration. Investigation and subsequent actions may be instituted as described in the Medical Staff Bylaws, Article VI. At a minimum, a letter of inquiry should be sent to the non-compliant on-call physician, requesting an explanation of his/her failure/lack of timely response to the request of the Emergency Medicine physician.
14. Quality Assurance Monitoring:
- a. Physician delay(s) as defined in this policy will be reviewed.
 - b. Patient transfer(s) due to lack of response of on-call physician(s) or refusal to respond to Emergency Medicine physician when notified.
15. CME:
- a. Provide a copy of current policy to each physician executing an agreement to provide on-call services.

D. **REFERENCE(S):**

1. 42 Code of Federal Regulations 489.24, Special Responsibilities of Medicare Hospitals in emergency cases. Medicare State Operations Manual, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospital in Emergency Cases, Rev. 60, 07-16-10.
2. California Hospital Association, EMTALA – A Guide to Patient Anti-Dumping Laws, 2012.
3. EMTALA Field Guide, Third Edition, Stephen A. Frew, JD and Kris Giese, MHA, CHC, MT(ASCP).

PHARMACY

ISSUE DATE: 09/90 **SUBJECT:** Drug Product Procurement and Inventory Management

REVISION DATE: 09/91, 01/97, 02/03, 01/05, 07/06, 07/09, 01/12, 09/15, 12/18, 12/22

Pharmacy Department Approval: ~~05/22~~12/25
Pharmacy & Therapeutics Committee Approval: ~~07/22~~12/25
Medical Executive Committee Approval: ~~09/22~~01/26
Administration Approval: ~~12/22~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 12/22

A. **POLICY:**

1. The Pharmacy Department shall be responsible for the procurement, distribution, and control of all drug products used in the hospital for inpatient and ambulatory patients.

B. **PROCEDURE:**

1. Medication Acquisition:
 - a. Pharmacy or Designee (i.e. **Supply Chain**/Materials Management) shall ensure the highest quality of and the best price for drug products through careful consideration and selection of drug product manufacturers and suppliers.
 - b. Only those medications approved for formulary use will be procured and stored as delineated in Pharmacy Policy Formulary System.
 - c. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form shall be procured.
 - d. Procurement of medications during emergencies shall be determined and performed as delineated in Pharmacy Policies Medication Shortages and Loaning and Borrowing of Medications for Emergency Purposes.
 - e. Antidote medications will be procured and stocked in accordance to Pharmacy Policy Antidote Stocking.
 - f. Orders will be made by the Pharmacy Buyer or designee and prepared daily using the wholesaler computerized ordering system or ordered directly from the manufacturer.
 - g. After the product is delivered directly to Pharmacy or via **Supply Chain**/Materials Management, the order will be checked against the packing slip and invoice.
 - i. If the items received were not accompanied by an invoice, drug products will be put aside until an invoice is obtained and the items are entered into inventory.
 - ii. Upon arrival of the order from the wholesaler the pharmacist will confirm the shipment container quantities match the expected quantities.
 - iii. If the order is complete, the pharmacist checking the order must initial and date the packing slip as an indication the products were received.
 - iv. If the order is incomplete, the Pharmacy Buyer will be notified and shall contact the appropriate wholesaler for rectification.
 - 1) Receipt of controlled substance medications shall be checked against the controlled substance packing slip for quantity and accuracy, signed and dated by a pharmacist.
 - 2) Any discrepancies shall be noted and referred to the appropriate person.

- 3) The CII Safe Receive Report is compared to the invoice to ensure all ordered products are accounted for and placed in the CII Safe.
 - h. A copy of each invoice will be forwarded to Accounts Payable.
 - i. A copy of Schedule II invoices shall be kept with the DEA order form filed for three years. Copies of Schedule III, IV, V invoices shall be kept in a separate file for three years.
2. Storage:
 - a. Medications shall be received, stored, and prepared under proper conditions in accordance with State and Federal Regulations, governing agencies, and manufacturer recommendations to ensure medication integrity, safety and security.
 - b. Storage of medications outside of the pharmacy shall be done in a secure manner, utilizing automated dispensing devices whenever possible.
 - c. Unusable drugs will be removed from stock as delineated in Pharmacy Policy Unusable and Outdated Drugs.

PHARMACY

ISSUE DATE: 01/72 **SUBJECT:** Hours of Operation and Authorized Access to the Pharmacy

REVISION DATE: 01/75, 01/80, 01/90, 01/00, 06/05, 07/06, 07/09, 01/12, 05/15, 07/18, 12/22

Department Approval:	07/22 12/25
Pharmacy & Therapeutics Committee Approval:	07/22 12/25
Medical Executive Committee Approval:	09/22 01/26
Administration Approval:	12/22 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **POLICY:**

1. As approved by the medical staff committees and Tri-City Medical Center (TCMC) administration, the Pharmacy hours of operation will be seven (7) days per week, 24 hours per day.
2. Access to the Pharmacy is limited to the Pharmacy staff.
 - a. Medical staff, nursing staff, administrative, environmental services and other personnel are authorized admission only in conjunction with their duties and under supervision of Pharmacy staff.

PULMONARY REHABILITATION

ISSUE DATE: 09/08 **SUBJECT:** Patient Enrollment Protocol

REVISION DATE: 12/12, 11/22

Department Approval:	09/2010/25
Division of Pulmonary Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	11/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/22

A. **PURPOSE:**

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

B. **POLICY:**

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

C. **GENERAL GUIDELINES:**

1. Patients seen during their inpatient stay shall be contacted to determine interest in the Outpatient Pulmonary Rehabilitation program.
2. Patient's primary physician or patient's Pulmonologist shall be contacted and admission to Pulmonary Rehabilitation requested. Physician approval shall be accompanied by signed referral.
3. Insurance authorization shall be obtained by staff members and patient shall agree to be responsible for any difference between amount billed and amount paid by insurance company, as well as any co-payment necessary under their insurance contracted benefits.
4. Patient shall come to Pulmonary Rehabilitation for intake and a patient history shall be obtained.
 - a. Physical, emotional and psychosocial limitations shall be assessed and documented, to ensure maximum benefit and safety of each participant
 - b. Relevant medical records shall be obtained and kept as a part of patient's record. These shall include but not be limited to, a discharge summary and recent PFT.

PULMONARY REHABILITATION

ISSUE DATE: 09/08

SUBJECT: Patient Referral

REVISION DATE: 12/12, 11/22

Department Approval:	02/20 12/25
Division of Pulmonary Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/22 01/26
Administration Approval:	11/22 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/22

A. **PURPOSE:**

1. To establish guidelines for patient referral for Pulmonary Rehabilitation Program.

B. **POLICY:**

1. All patients must be referred to the Pulmonary Rehabilitation Program by a physician order after the patient meets the "Criteria for Patient Selection."

C. **GENERAL GUIDELINES:**

1. The physician shall sign the referral, and, if possible, provide recent laboratory results.
2. If the patient's primary physician or cardiologist does not feel an exercise stress test is necessary or appropriate at this time, target heart rate shall be determined and monitored by the Pulmonary Rehabilitation staff using age determined target heart rate ranges and/or rest plus 30 beats the patient's perceived exertion shall not exceed the Borg Scale of 5.



PROCEDURE: RADIOLOGIST'S COVERAGE NON-INTERVENTIONAL RADIOLOGY 7633-125

Purpose: To ensure efficient physician oversight/coverage of procedures performed in diagnostic radiology service areas to reduce waiting times

A. PROCEDURE:

1. The Radiologists ~~scheduled specialty~~ **schedule** assignments will be posted ~~e-reading room-on the Tri City Medical Center Intranet~~ **Intranet**. ~~Their daily schedule, including information on days off will be posted. The schedule board will be updated daily.~~
2. ~~I~~**I**n order to minimize patient waiting times, a technologist should not wait more than 15 minutes for a radiologist to arrive in the procedure area. If the radiologist assigned to the area is unavailable, the technologist shall then seek another radiologist to perform the needed service.
3. If a technologist has waited more than the 15 minutes and cannot find another radiologist to perform the case, then the technologist should immediately contact the supervisor of the area or contact the department manager or director for assistance.

Radiology Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/18, 10/25	10/18, 12/25	n/a	11/18, 01/26	01/19, 02/26	n/a	02/11, 01/19

REHABILITATION SERVICES

ISSUE DATE: 04/95 SUBJECT: Community Out-Reach
ClassesGroups

REVISION DATE: 09/97, 01/00, 01/03, 01/06, 01/09,
05/12, 08/17, 11/22

Department Approval: 08/2208/25
Department of Medicine Approval: 08/2211/25
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 10/2201/26
Administration Approval: 11/2202/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 11/22

A. POLICY:

1. Community Out-Reach-Groups **Classes** are provided in a social/group setting to emphasize sustaining or returning to the highest level of functioning within the individual's home and in the community.

B. PROCEDURE:

1. Requests for Service:
 - a. Participants will be self-referred or referred by a healthcare professional to attend **community classes**. ~~group treatment~~, Per the following guidelines, the **community member patient** should display the following:
 - i. Appropriate level of motivation to participate and benefit from **community class** ~~group treatment~~.
 - b. Appropriate comprehension necessary to understand simple directions and be able to attend for one hour.
 - b.c. **Participants are also encouraged to bring a caregiver or family member to assist, if prudent.** ~~Have a realistic expectation of group therapy goals.~~
2. Hours of Service:
 - a. One ~~classsession~~ weekly for one hour, subject to change due to community needs.
3. Responsibilities:
 - a. **Community Classes** ~~Group therapy~~ will involve utilization of multi-modal communication skills. ~~Groups and group goals will be selected pertinent to participants' wants and needs.~~
 - b. **The titles of the community classes** ~~Groups~~ may include, but will not be limited to:
 - i. **Communication Group:** ~~Aphasia Group~~
 - 1) This ~~classgroup~~ is for individuals who have difficulty with speech and/or language skills and whose personal therapy may have been completed or discharge from therapy is forthcoming. This is language therapy in a group setting, emphasizing social communication skills solving communication problems within the community and promoting multimodal communication skills.
 - ii. Parkinson's **Exercise Group:**
 - 1) This exercise program is designed ~~s~~ to improve the quality of life for those with Parkinson's disease. The purpose is to help maintain maximum function. The Class begins with a warm-up, followed by upper extremity,

lower extremity and trunk strengthening, then a fun activity to increase coordination, balance or mobility. The session ends with a cool-down activity. Participants are also given written exercises to perform at home and are encouraged to ask questions relating to their disease process.

iii. Stroke Exercise Group:

- 1) This group is geared toward clients who have been discharged from therapy services and are looking for a continued exercise program for maintenance, learning new techniques, friendships, or just getting out. We begin with a stretching warm-up, upper extremity exercises, lower extremity exercises, balance activities and then a few fun activities.

REHABILITATION SERVICES

ISSUE DATE: 10/88 SUBJECT: Discharge Criteria

REVISION DATE 01/91, 01/94, 04/95, 09/97, 03/00,
01/06, 03/12, 03/16, 12/19, 12/22

Rehabilitation Department Approval:	08/2208/25
Department of Medicine Chiefs Approval:	08/2211/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. POLICY:

1. To establish guidelines for discharging patients from Physical Therapy, Occupational Therapy, Speech Therapy, and Therapeutic Recreation Services.

B. PROCEDURE:

1. Criteria:
 - a. Rehabilitation Services are no longer clinically indicated and medically necessary for the treatment of the individual's illness or injury.
 - b. There are no longer valid expectations for significant practical improvement in the level of functioning within a reasonable length of time. Care is at a maintenance level.
 - c. Specified goals and/or prior level of function have been met.
 - d. With surgery or major medical complication, patient treatment will be put on hold or the patient will be considered for discharge pending physician or non-physician practitioner orders.
 - e. The patient's mental function is insufficient to participate or recall information and no family nor caregiver available for training.
 - f. Appointment Cancellation or failure to show for two scheduled outpatient therapy visits.
 - g. Patient is unable or repetitively refuses to follow through with the established treatment plan as established upon therapy evaluation.
 - h. Patient is transferred to another facility, discharged from the hospital, or expires.
2. Process:
 - a. **During the patient's hospital stay, the physician or non-physician practitioner may determine the patient is not appropriate for further therapy services and may cancel the therapy order/s.** ~~It is the responsibility of the physician to determine discharge from the Rehabilitation Service the patient is receiving.~~
 - b. In the course of treatment, the therapist may determine the patient no longer requires therapy services, or that intervention for the medical problem for which services were being provided is no longer indicated, and is documented in the Medical Record.
 - c. A discharge summary may be documented in the medical chart showing progress or lack of progress made during the therapy sessions. A final progress note or discharge summary is sent to the referring physician for Outpatient Services.

REHABILITATION SERVICES

ISSUE DATE: 07/91 **SUBJECT:** Documentation of Progress Note and Discharge Summary

REVISION DATE: 02/94, 09/97, 01/00, 01/03, 01/06,
01/09, 05/12, 03/16, 10/19, 12/22

Rehabilitation Department Approval:	08/2209/25
Department of Medicine Approval:	08/2211/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. POLICY:

1. All documentation of treatments performed will adhere to Centers for Medicare and Medicaid Services (CMS) Guidelines in accordance with Medicare Benefits Policy Chapter 15 Section 220.0 through 220.

B. PROCEDURE:

1. Information regarding progress will be displayed in the patient's medical record. Progress notes or discharge summaries will be documented on the appropriate form and will be provided for referring or treating physicians.
2. Documentation must reflect status regarding the long and/or short-term goals that have been met or which have been modified if necessary, the plan of care for continued treatment, if indicated, or any changes in focus or frequency of treatment, including discharging current services.
3. Each documentation for progress note or discharge summary may include, but is not limited to the following information:
 - a. Background information with admitting diagnosis, evaluation date, admitting physician, type of therapy and total therapy visits to date.
 - b. Objective measure of therapy outcome for current goals.
 - c. Assessment of patient's deficits, strengths, and rehabilitation potential, and education provided according to patient/family education needs.
 - d. Recommended plan of care or termination of skilled therapy services, which may or may not include updating functional short and/or long-term goals, and prognosis.
 - e. Therapist's signature and/or co-signature for supervised providers as indicated.

C. REFERENCE(S):

1. Centers for Medicare and Medicaid Services. (2014, December 31). *Medicare Benefits Policy, Chapter 15, Section 220.0-220.4*. Retrieved July 3, 2015, from www.cms.gov: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>

REHABILITATION SERVICES

ISSUE DATE: 09/91 SUBJECT: Home Evaluation

REVISION DATE: 01/94, 12/96, 03/00, 01/06, 03/12,
06/13, 04/19, 12/22

Rehabilitation Department Approval: 08/2208/25
Department of Medicine Approval: 08/2211/25
Pharmacy & Therapeutics Committees Approval: n/a
Medical Executive Committee Approval: 09/2201/26
Administration Approval: 12/2202/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 12/22

A. **POLICY:**

1. The primary OT, PT and/or SLP (if appropriate) will assess if patient requires a home evaluation. The home evaluation will be conducted while the patient is receiving inpatient acute rehabilitation.

B. **PROCEDURE:**

1. At least one staff OT or PT will conduct the home evaluation. Other participants may include OTA, PTA, SLP, Rehab Aide or interns
2. Therapist(s) will coordinate the home evaluation time and discuss transportation arrangements for patient with their family member/caregiver prior to the evaluation.
3. Transportation for patient will be provided by the patient's family.
4. A temporary absence release form must be filled out by the patient or representative before the home evaluation. A form is placed in the chart, and a copy is given to the patient.
5. The therapist will leave documentation of their scheduled trip at Rehab Services with address of the Home Evaluation location and an emergency number which includes a work and one personal contact phone number. The therapist will carry a copy of this with them in the car.
6. The therapist(s) will notify the patient's nurse about the patient's absence from the unit due to the Home Evaluation.
7. The therapist(s) are responsible for taking necessary equipment, e.g.: tape measure, bath bench, transfer boards, and appropriate forms, on the home evaluation.
8. The therapist(s) will document results of Home Evaluation in the medical chart and order any specialized equipment.
9. **Home evaluations prior to discharge shall be conducted only in exceptional circumstances where significant safety concerns are identified. These evaluations are reserved for cases in which the patient is transitioning to outpatient services without a home health plan, and where environmental barriers – such as multiple stairs requiring assessment and trial of adaptive equipment (e.g., electric stair climbers)—pose a substantial risk to safe return home. Other major safety concerns may also warrant evaluation at the discretion of the clinical team.** ~~Home Evaluation with concurrent patient discharge from Tri-City Medical Center (TCMC) to their home may occur at times. A discharge home is determined by the patient's physician at TCMC and is based on the patient meeting pre-established functional and medical safety criteria. The physician may reconsider patient discharge home following specific findings of the Home Evaluation.~~

C. **FORM(S):**

1. Temporary Absence Release Form -- Sample

Temporary Absence Release Form – Sample

A patient outing (explain activities to occur during patient outing) _____
_____ will occur away from the hospital at
(location) _____
on (date) ___/___/___ and will last approximately (time) _____(AM/PM) to _____(AM/PM).

Patients who participate in the outing are accompanied by hospital employees or agents who are responsible for the supervision of the patients and for providing or arranging, when appropriate, transportation by hospital vehicles or commercial carriers to and from the activity. A patient may participate in the outing if his/her physician deems such participation therapeutically appropriate and beneficial. However a patient may continue to receive other services from the hospital even if permission is not given for participation in the outing, which is a special treatment modality.

Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of the time during and subsequent to the time a patient is away from the hospital. If private or public insurance does not provide such hospitalization benefits, the patient or the person responsible for the patient's hospitalization expenses will remain, to the extent permitted by law obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners. Your signature below constitutes your acknowledgement: (1) that you have read and agree to the forgoing; (2) that the patient outing noted above has been adequately explained to you by your/ the patient's physician and that you have received all the information you desire concerning the outing; and (3) that you authorize and consent to the participation of (patient name) _____ in such outing.

Patient/Conservator/Guardian/Other Signature Date / Time

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/Conservator/Guardian/Other)



**CONSENT FOR PARTICIPATION
IN TRI-CITY HOSPITAL
PATIENT OUTING**

White - Hospital Yellow -Patient

Affix Patient Label

REHABILITATION SERVICES

ISSUE DATE: 02/18 **SUBJECT:** Occupational Therapy Assistant Supervision

REVISION DATE: 02/18, 11/22

Rehabilitation Department Approval:	08/2208/25
Department of Medicine Approval:	08/2211/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	11/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/22

A. POLICY:

1. The Occupational Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the occupational therapy assistant does not function autonomously.

B. PROCEDURE:

1. Appropriate supervision of an occupational therapy assistant includes, at a minimum:
 - a. The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.
 - b. -Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.
 - c. The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.
 - d. The supervising occupational therapist shall provide periodic on-site supervision and observation of client care rendered by the occupational therapy assistant.
 - e. The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.
 - f. The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.
 - g. Occupational therapy assistants may supervise:
 - i. Level I occupational therapy students;
 - ii. Level I and Level II occupational therapy assistant students; and
 - iii. Aides providing non-client related tasks.

~~h. The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.~~

C. **REFERENCE(S):**

1. ~~California Code of Regulations Board Of Occupational Therapy Regulations. (202515). Title 16, Division 39, Sections 4180-4184.~~
2. ~~California Code of Regulations Board of Occupational Therapy. <https://www.bot.ca.gov>.~~
- 2.3. **American Occupational Therapy Association (OTA). (2021). Standards of Practice for Occupational Therapy.**

REHABILITATION SERVICES

ISSUE DATE: 09/91 **SUBJECT:** Occupational Therapy

REVISION DATE: 01/94, 09/97, 03/00, 01/03, 01/06,
01/09, 03/10, 04/12, 03/16, 04/19,
11/22

Rehabilitation Department Approval:	08/22 09/25
Department of Medicine Chiefs Approval:	08/22 11/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19 11/22

A. POLICY:

1. Occupational Therapy is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
2. Occupational Therapy Staff reports to the **Rehabilitation Department** Leadership Structure in fulfilling duties and responsibilities.

B. PROCEDURE:

1. Requests For Service:
 - a. All requests for occupational therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP).
 - b. Verbal requests for occupational therapy services will be accepted **for immediate needs**, but must be followed by a written order, **as per regulatory standards**.
 - c. A new order is required for any change in medical status or **prescribed treatment plan**~~treatment ordered~~.
2. Hours Of Service:
 - a. Inpatient care: Monday through Sunday, 0800 to 1630. ~~for inpatient care.~~
 - b. Outpatient: Monday through Friday, 08700 to 1630.
 - c. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities:
 - a. Provides occupational therapy evaluations and treatment as prescribed by a licensed physician or AHP.
 - b. Administers an assessment of Occupational Performance.
 - c. Develops an Intervention Plan for each individual with designated goals based upon the individual's medical condition, assessment and personal goals.
 - d. **Establishes and monitors** ~~Develops~~ Outcomes and Measures to assess the individual's progress or regression.
 - e. Implements the Intervention Plan, utilizing specific activities or methods to ~~develop or~~ restore function, compensate for **deficits, or reduce impairment**~~dysfunction or minimize debilitation~~.
 - f. **Regularly reviews and adjusts the plan of care based on clinical indication and patient response.** ~~Engages in Intervention Plan Review, modifying treatment based on established Outcomes and Measures, as clinically indicated and medically necessary.~~

- g. Treatment may include but is not limited to:
 - i. Use of therapeutic tasks and purposeful activities to promote psychological, cognitive, physical, sensory ~~integrative~~ and developmental functioning.
 - ii. Facilitate **training and education in** ~~and educate in graded self-care, and~~ **activities of daily-living (ADLs) tasks, social interaction** ~~socialization skills,~~ pre-vocation ~~and skills,~~ vocational roles, and community reintegration with regard to patients' privacy and dignity. This may involve instructing in the use of compensatory techniques; selecting, constructing and instructing in the use of adaptive devices, orthoses, and prostheses; ordering appropriate equipment and **environmental modification to optimize functional performance.** ~~recommending adaptation of the individual's physical environment to enable optimal function.~~
 - iii. Use of **therapeutic** exercises and other specific techniques ~~such as these~~ to promote relaxation, **enhance strength and range of motion, and improve posture** ~~restore movement, strength and posture in preparation for functional training.~~
- h. Documents **all services and clinical** ~~patient treatment and treatment outcomes in~~ patient's legal **medical record in compliance with** ~~per~~ American Occupational Therapy Association/Centers for Medicare and Medicaid Services Guidelines for Documentation of Occupational Therapy.
- i. Maintains ongoing **communication and collaboration** ~~reporting and consultative role~~ with appropriate health care professionals regarding patient's current status.
- j. Identifies safety hazards and **faulty** equipment ~~in disrepair,~~ removes hazard or equipment and **submits** ~~inputs~~ work order.
- k. Demonstrates fiscally responsible decision making including **managing time,** ~~the prudent use of therapy~~ **therapy** equipment and supplies, and ~~conservation of time~~ and resources in a manner that maintains desired income and expense ratios.
- l. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

C. **REFERENCE(S):**

1. American Occupational Therapy Association (2014). Occupational therapy practice framework: Domain and process (3rd ed.). *American Journal of Occupational Therapy*, 68(Suppl.1), S1–S48. <http://dx.doi.org/10.5014/ajot.2014.682006>
2. **Clark, G.F, Madigan, M.J.** ~~Gloria Frolek Clark, M. J.~~ (2013). Guidelines for Documentation of Occupational Therapy. (2013 ~~T. C. 2012, Ed.~~) *American Journal of Occupational Therapy*, 67(November/December), 32-38.
3. Centers for Medicare & Medicaid Services. (2022 ~~15, May~~). ***Complying With Outpatient Rehabilitation Therapy Documentation Requirements (ICN 905365)***. Retrieved from: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications-items/cm51248602Therapy_Services. Retrieved from ~~www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf~~
4. Centers for Medicare & Medicaid Services. (2025 ~~15, May~~). ***Outreach and Education/Medicare-Learning Network MLN/MLNMattersArticles/Downloads/MM6698.pdf***. Retrieved from ~~www.cms.gov: Medicare Learning Network (MLN)~~. Retrieved from: <https://www.cms.gov/MLNGenInfo>

REHABILITATION SERVICES

ISSUE DATE: 08/91 SUBJECT: Outpatient Medical Records

REVISION DATE: 02/94, 09/97, 10/99, 01/06

REVIEW DATE: 01/03, 01/09, 04/12, 08/19,
12/22

Rehabilitation Department Approval:	08/2209/25
Department of Medicine Approval:	08/2211/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **POLICY:**

1. All outpatients accepted for treatment will have a completed medical record compiled and maintained.

B. **PROCEDURE:**

1. The Office Coordinator, Clerk Receptionist, or Rehabilitation Aide will be responsible for **uploading the following to the electronic** ~~obtaining or creating the file and paperwork necessary for the medical record:-~~
 2. ~~Each medical record will contain the following:~~
 - a. ~~Outpatient Admission Form: To include patient's name, address, medical record number, social security number, insurance information, age, sex, marital status, religion, date of admission, admitting physician, initial diagnostic impression, and diagnosis.~~
 - ~~b.a.~~ **Physician's Prescription/Referral Authorization: which includes diagnosis and ICD Code, physician signature, **patient name in full** and date signed.**
 - c. ~~A signed Conditions of Admissions Form: If the patient is under 18 years of age, they must be accompanied by an adult who assumes responsibility for care during therapy sessions. This includes signature for authorization of treatment and completion of Medical History and Physical form.~~
 - ~~History and Physical Intake form.~~
 - b. Evaluations, progress notes, plan of care, and discharge notes.**
 - c. Any pertinent clinical notes.**
 - d. No show/cancellation notes.**
 - ~~e. Discharge Summary from other facilities, if available/ appropriate.~~
 - ~~f. Copy of insurance card(s) and authorization as appropriate.~~
 - ~~g. Signed Cancellation/No Show policy~~
 - ~~h. Health Insurance Portability And Accountability (HIPAA) form and workers' compensation release of information form, if applicable.~~
 - ~~i. Signature Log~~
 - 3.2. Once the patient has been seen, an evaluation will be documented and placed in Electronic Medical Record (EMR).
 - a. The initial evaluation will be faxed to the physician for signature and scanned into the EMR.
 - 4.3. Progress will be documented after every patient visit.

- a. Progress summaries will be written by each appropriate therapist every ~~4~~ 40-visits, or per authorization as appropriate. A copy will be faxed to the referring physician, and scanned into the EMR.
- 5.4.** A discharge summary including patient/family teaching and continuation of services referral.
- a. A copy is to be faxed to the physician and scanned into the patient's EMR.

REHABILITATION SERVICES

ISSUE DATE: 02/97 SUBJECT: Physical Therapy Assistant Supervision

REVISION DATE: 01/06, 01/09, 04/12, 05/15,
01/19, 12/22

Rehabilitation Department Approval:	08/2209/25
Department of Medicine Approval:	n/a 11/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	11/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **POLICY:**

1. ~~To comply with the Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44 for adequate supervision of Physical Therapy Assistants.~~
- 2.1. **The Physical Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the physical therapy assistant does not function autonomously. Licensed Physical Therapy Staff shall be responsible for monitoring the clinical progress of each patient, delivering direct physical therapy services, and ensuring that Physical Therapist Assistants (PTAs) operate under appropriate supervision. The supervising Physical Therapist retains full responsibility for all care provided by the PTA and must ensure that the PTA does not function independently, in accordance with California Code of Regulations Title 16, Section 1398.44.**

B. **PROCEDURE:**

1. ~~Adequate supervision shall include all of the following:~~
 - a. ~~The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapy assistant at all times while the physical therapy assistant is treating patients. The supervising physical therapist shall provide supervision of the assigned patient care rendered by the physical therapy assistant.~~
 - b. ~~The supervising physical therapist shall initially evaluate each patient and document in the patient's record, along with his or her signature, the evaluation and the plan of care.~~
 - c. ~~The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available. This information shall be communicated verbally or in writing by the supervising physical therapist to the physical therapy assistant prior to initiation of treatment by the physical therapy assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapy assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education, and training of the physical therapy assistant.~~
 - d. ~~The supervising physical therapist shall re-evaluate the patient if necessary, and modify the treatment goals and plan as needed. The re-evaluation shall include treatment to the patient by the supervising physical therapist. The re-evaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect~~

~~the patient's progress toward the treatment goals and when the next re-evaluation shall be performed.~~

- ~~e. The physical therapy assistant shall document each treatment in the patient's record, along with his or her signature. The physical therapy assistant shall document in the patient's record and notify the supervising physical therapist of any change in the patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a re-evaluation by a supervising physical therapist before further treatment by the physical therapy assistant.~~

1. Supervision Standards for Physical Therapist Assistants (PTAs):

Adequate supervision of PTAs shall include the following components, in accordance with California Code of Regulations Title 16, Section 1398.44:

a. Availability of Supervising Physical Therapist:

The supervising Physical Therapist (PT) must be continuously accessible to the PTA during patient care activities, either in person or via telecommunication. The PT is responsible for overseeing all delegated patient care provided by the PTA.

b. Initial Evaluation and Documentation:

The PT shall perform and document the initial evaluation of each patient, including the plan of care. This documentation must be signed and dated by the PT and entered into the patient's medical record.

c. Treatment Planning and Delegation:

The PT shall establish and document treatment goals and a comprehensive plan based on the evaluation and relevant clinical information. This plan must be communicated to the PTA—verbally or in writing—prior to the initiation of treatment. The PT shall determine which components of the treatment plan may be delegated to the PTA, ensuring that such delegation aligns with the PTA's demonstrated competencies, including education, training, and clinical experience.

d. Re-evaluation and Plan Modification:

The PT shall re-evaluate the patient as clinically indicated, including direct treatment during the re-evaluation. Any modifications to the treatment goals or plan must be documented and signed by the PT, reflecting the patient's progress and specifying the timeline for the next re-evaluation.

e. PTA Documentation and Reporting:

The PTA shall document each treatment session in the patient's record, including their signature. Any observed changes in the patient's condition that deviate from expected progress or treatment goals must be documented and promptly reported to the supervising PT. Such changes require a formal re-evaluation by the PT prior to continuation of treatment by the PTA.

D. REFERENCE(S):

1. Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44

REHABILITATION SERVICES

ISSUE DATE: 01/91 SUBJECT: Physical Therapy

REVISION DATE: 01/94, 09/97, 03/00, 01/03, 01/06,
01/09, 03/10, 04/12, 03/16, 04/19,
12/22

Rehabilitation Department Approval:	08/2209/25
Department of Medicine Chiefs Approval:	08/2211/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	03/1901/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **POLICY:**

- ~~1. Physical Therapy is accountable through the Rehabilitation Services Leadership Team and/or Medical Director of the rehabilitation program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate Administrative Executive to the Administrator for carrying out the policies and procedures as approved by the Governing Board.~~
- ~~2. Physical Therapy staff report directly to the Rehabilitation Services Leadership Team in fulfilling duties and/or responsibilities.~~
- 1. The Physical Therapy Department shall maintain a competent standard of clinical practice under the oversight of the Rehabilitation Services Leadership Team, the Medical Director of the acute rehabilitation program, and the referring physician, as appropriate. The Department is further accountable to the *designated Administrative Executive* and ultimately to the *Hospital Administrator* for adherence to institutional policies and procedures as approved by the Governing Board.**
- 2. Physical Therapy staff shall report directly to the Rehabilitation Services Leadership Team in the execution of their clinical duties, administrative responsibilities, and professional obligations, in accordance with hospital organizational structure and applicable state regulations.**

B. **PROCEDURE:**

- ~~1. All requests for Physical Therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP). AHP must be working in collaboration with a physician.~~
- ~~2. Verbal requests for Physical Therapy services will be accepted, but must be followed by a written prescription.~~
- ~~3. A new signed prescription is required for any change in medical status or treatment ordered.~~
- ~~4. Outpatient appointments are scheduled between 0700 and 1800 Monday through Friday.~~
- ~~5. Inpatients are seen between 0800 and 1630 Monday through Sunday according to prioritization policy.~~
 - ~~a. Therapy provision may occur outside of these time frames on an as-needed basis.~~
- ~~6. Physical Therapy evaluations and treatment will be provided as prescribed by a licensed physician or an AHP.~~
- ~~7. Appropriate assessments/tests will be administered to develop a treatment plan.~~

- ~~8. A written treatment plan will be provided with time frames for each individual with designated functional goals, based upon the individual's medical condition, evaluation and test results, and personal goals.~~
- ~~9. Initial and ongoing treatment will be implemented utilizing specific activities or methods to develop or restore function, relieve pain, compensate for dysfunction or minimize debilitation. Treatment may include but is not limited to:
 - ~~a. The use of physical agents such as thermotherapy, cryotherapy, hydrotherapy, electrical stimulation, ultrasound, and mechanical traction.~~
 - ~~b. Therapeutic exercise and activities, manual therapy and joint mobilizations.~~
 - ~~c. Neuromuscular re-education, gait training, vestibular integration.~~
 - ~~d. Manual lymphatic drainage and bandaging.~~~~
- ~~10. Treatment will be modified based upon progression towards therapeutic goals as clinically indicated and medically necessary.~~
- ~~11. Patient treatment and treatment outcomes will be documented in the patient's legal record according to appropriate documentation policies.~~
- ~~12. Patient's physician will be provided with a written summary of the patient's evaluation, progress and designated discharge plan for treatments.~~
- ~~13. All therapy equipment will be maintained in quality condition.
 - ~~a. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.~~~~
- ~~14. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.~~
- ~~15. Appropriate operational and administrative records will be maintained, may include but not limited to licensure, certifications, timecards, training records, and billing sheets.~~
- ~~16. Reporting and consulting with appropriate healthcare professionals regarding patient's current status will be maintained and documented.~~

C. RELATED DOCUMENT(S):

1. Documentation of Evaluations
2. Documentation of Daily Notes
3. Documentation of Progress Notes

Documentation of Discharge Summaries

1. **All requests for Physical Therapy services must be supported by a written prescription from a licensed physician or an Allied Health Professional (AHP) acting in collaboration with a physician, in accordance with California Code of Regulations Title 22, §51309.**
2. **Verbal orders for Physical Therapy services may be accepted in urgent situations but must be followed by a written prescription within a timeframe consistent with hospital policy and regulatory standards.**
3. **A new signed prescription is required when there is a change in the patient's medical status or when a modification to the treatment plan is ordered.**
4. **Outpatient Physical Therapy services are scheduled Monday through Friday between 08:00 and 16:30 hours.**
5. **Inpatient Physical Therapy services are provided daily between 08:00 and 16:30 hours, including weekends, based on clinical prioritization protocols.
 - a. Services may be rendered outside of these hours when medically necessary or as determined by clinical judgment.****
6. **Physical Therapy evaluations and treatments shall be administered only as prescribed by a licensed physical therapist.**
7. **Licensed Physical Therapists shall conduct appropriate assessments and standardized tests to develop an individualized treatment plan.**
8. **A written treatment plan shall be developed for each patient, including timeframes and measurable functional goals. Plans must be based on the patient's medical condition, evaluation findings, test results, and personal goals.**

- 4.9. Treatment interventions shall be implemented to improve or restore function, alleviate pain, compensate for impairments, or minimize disability. Interventions may include, but are not limited to:
 - a. Physical agents: thermotherapy, cryotherapy, hydrotherapy, electrical stimulation, ultrasound, mechanical traction
 - b. Therapeutic exercises, manual therapy, joint mobilizations
 - c. Neuromuscular re-education, gait training, vestibular rehabilitation
 - d. Manual lymphatic drainage and compression bandaging
10. Treatment plans shall be modified as clinically indicated based on patient progress and medical necessity.
11. All treatment sessions and outcomes shall be documented in the patient's legal medical record in accordance with hospital documentation standards and applicable regulations.
12. A written summary of the patient's evaluation, progress, and discharge plan shall be provided to the referring physician or AHP.
13. All therapy equipment shall be maintained in safe and functional condition.
 - a. Staff shall identify and report safety hazards or equipment in disrepair, remove unsafe items from use, and initiate corrective work orders.
14. Staff shall demonstrate fiscally responsible decision-making, including efficient use of equipment, supplies, time, and resources to support departmental financial goals.
15. Operational and administrative records shall be maintained in accordance with hospital policy and regulatory requirements. These may include licensure verification, certifications, timekeeping records, training documentation, and billing forms.
- 5-16. Ongoing communication and consultation with appropriate healthcare professionals regarding the patient's status shall be documented in the medical record.

C. RELATED DOCUMENT(S):

1. Documentation of Evaluations
2. Documentation of Daily Notes
3. Documentation of Progress Notes
4. Documentation of Discharge Summaries

D. REFERENCE(S):

1. ~~California Physical Therapy State Practice Act. (n.d.). Physical Therapy Board of California. Retrieved July 7, 2015, from Physical Therapy Board of California Website: <http://leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2620-2634>~~
- 4.2. **California's Physical Therapy Practice Act, Title 22 of the California Code of Regulations**

REHABILITATION SERVICES

ISSUE DATE: 08/90 SUBJECT: Referrals for Rehabilitation Services

REVISION DATE: 01/91, 01/94, 09/97, 10/00, 01/03,
01/06, 01/09, 03/10, 04/12, 06/13,
04/19, 12/22

Rehabilitation Department Approval:	08/2208/25
Department of Medicine Approval:	08/2211/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **PURPOSE:**

1. Rehabilitation services are rendered according to the written orders of a Physician or an Allied Health Professional (AHP), such as a Physician Assistant, Clinical Nurse Specialist or Nurse Practitioner. The Physician/AHP is to determine the need for therapy, the tolerance and capabilities of the patient and the treatment objectives.
 - a. ~~The Physician/AHP, in consultation with the therapist, must prescribe the specific procedures/modalities to be used and the frequency and duration of treatment.~~
 - a. The referring Physician/AHP should then notate the order under the "orders" tab in the patient's Electronic Medical Record (EMR), for inpatients; or complete an appropriate referral form, **and the form should be faxed to (760) 940-7004** or his own personal prescription form, with the required information for outpatients.
 - b. **i. Once orders have been received and initial patient evaluation completed, the evaluating therapist will determine the treatment plan, as well as the frequency and duration.**
 - e.b. The dated prescription must include a specified diagnosis or description of the problem, therapy orders, frequency and duration, and a signature.
 - d.c. These forms will ~~then be forwarded to the Rehabilitation Services Department.~~ **be reviewed for completeness by the front office staff, or designee, and scheduled as appropriate.**

B. **REQUESTS FOR SERVICE:**

1. Verbal orders may be taken by a physical therapist (PT), occupational therapist (OT), or speech and language pathologist (SLP) from a Physician/AHP.
2. These must be charted and signed by the physical therapist, occupational therapist or speech and language pathologist read back and verified with the ordering Physician/AHP verbatim.
3. A written **or electronic** order shall be obtained from the referring Physician/AHP within a reasonable time frame.

C. **HOURS OF SERVICE:**

1. Inpatient **acute care patientss** are seen for an evaluation within **48** 24-hours for PT, OT and high-priority Speech patients 7 days a week.
2. Referrals received after 4 PM on Friday for Speech are evaluated within 72 hours.
3. Outpatients are scheduled as quickly as possible, not to exceed 7 business days.

D. **RESPONSIBILITIES:**

1. Rehabilitation services must be provided by, or under, the supervision of a Rehabilitation Services staff member who meets the qualifications established by applicable federal, state and local laws and regulations.
2. Whenever a rehabilitation service is given by a person who does not meet these regulations, the qualified therapist shall be immediately available to supervise and/or handle any emergency that may arise during treatment.
3. After the initial assessment is completed, the Physician/AHP will sign off on the therapist's proposed plan of care. The sign-off will be in the form of a clarification order (inpatient) or an updated therapy prescription form (outpatient) or by signing the therapist's evaluation/report and plan of care (outpatient).

REHABILITATION SERVICES

ISSUE DATE: 07/91 SUBJECT: Scope of Services

REVISION DATE: 01/94, 05/95, 04/97, 10/00, 05/01,
02/03, 01/06, 01/09, 03/12, 03/16,
04/19, 12/22

Rehabilitation Department Approval:	08/2208/25
Department of Medicine Approval:	08/2211/25
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	09/2201/26
Administration Approval:	12/2202/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/22

A. **POLICY:**

1. The Department of Rehabilitation Services includes Physical, Occupational, and Speech Therapies, Audiology, and Therapeutic Recreation. Using a multidisciplinary collaborative team approach, services and programs are available to meet the needs of all patients with a wide variety of diagnoses, ~~including physical and psychosocial disabilities.~~ The overall objective of the **Rehabilitation** Department is to foster a healing environment for patients to regain their functional independence in all areas of daily life as rapidly as possible. Assessment identifies the patient's physical, cognitive, behavioral, communicative, emotional and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include:
 - a. Emotional, behavioral or mental disorders
 - b. Cognitive disorders
 - c. **Communication** ~~Communicative~~ disorders
 - d. Developmental disabilities
 - e. Vision or hearing impairments or disabilities
 - f. Physical impairments or disabilities
 - g. Pain interfering with optimal level of function or participation in rehabilitation
2. Each patient, **regardless of age**, ~~inclusive of neonatal through geriatric ages,~~ will be treated with dignity and respect. **The highest level of care** ~~Optimal health care services~~ will be delivered to each patient regardless of gender, size, disability, race, creed, **sexual orientation or identification**, or ethnic origin.
3. Physical Therapy - The goals of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning. Physical Therapy Services shall include, but are not limited to, evaluation/assessment, development of treatment plans and goals, instruction, education and consultation services.
4. Occupational Therapy - The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skills required for daily living activities. Services include evaluation and treatment for impairments of physical, psychosocial, cognitive, developmental and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and compensate for or cope with disabling conditions.

5. Speech Pathology - Speech-Language Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders. These include, but are not limited to, impairments of articulation, language comprehension and expression, cognition, fluency, voice, reading, writing and swallowing. Education and counseling for families of patients exhibiting the aforementioned disorders are also provided.
6. Audiology Services – Audiology Services include assessment of hearing acuity and status in patients who may be at risk for changes in hearing due to medical or treatment issues, including medication, age or diagnosis. Instruction and education of patients and family members is provided to increase the involved person’s understanding of their deficits.
7. Therapeutic Recreation - Therapeutic Recreation Services provide goal-oriented programs that promote wellness and improve the patient’s quality of life through leisure. Therapeutic Recreation treatment may be individual or done in groups. Services include, but are not limited to, leisure assessment and evaluation, skill development, social programs, special events, leisure education, leisure counseling and resource development. Family education and counseling are included to improve patient’s attitude, skill level and socialization.

REHABILITATION SERVICES

ISSUE DATE: 05/18 **SUBJECT:** Supervision of Patients - Outpatient

REVISION DATE: 05/18, 11/22

Department Approval:	08/22 08/25
Department of Medicine Approval:	08/22 11/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/22 01/26
Administration Approval:	11/22 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/22

A. POLICY:

1. All physical, occupational and speech and language pathology evaluations and treatments will be directed and supervised by discipline specific licensed clinical staff.

B. PROCEDURE:

1. Licensed clinical staff includes: Physical Therapists (PT), Occupational Therapist, Speech and Language Pathologists and Physical/Occupational Therapy Assistants.
2. Support Staff may include PT Aides and Rehabilitation Aides.
3. Support staff may carry out tasks under the guidance of the Licensed Physical/Occupational Therapists in supporting patient therapy sessions as per the guidelines established by the state and discipline specific regulatory body.

C. REFERENCE(S):

1. California Physical Therapy State Practice Act. (n.d.). Physical Therapy Board of California. Retrieved July 7, 2015, from Physical Therapy Board of California Website:
<http://leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2620-2634>
2. California Board Of Occupational Therapy Regulations. (2015). *Title 16, Division 39 California Code of Regulations*.

REHABILITATION SERVICES

ISSUE DATE: 09/91 SUBJECT: Therapeutic Recreation Department Policy

REVISION DATE: 01/94, 09/97, 01/06, 01/09, 04/12, 05/12, 04/19, 12/22

Rehabilitation Department Approval: 08/2208/25
Department of Medicine Approval: 08/2211/25
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: 09/2201/26
Administration Approval: 12/2202/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 12/22

A. **POLICY:**

1. Patients referred for therapeutic recreation will be evaluated, and recommendations will be established as clinically indicated. Therapeutic recreation is accountable through the leadership structure of **the Rehabilitation Services department** and the referring physician/Allied Health Professional (AHP) for maintaining a competent level of practice. The department is also accountable through the appropriate administrative executive for carrying out the policies and procedures as approved by the Governing Board.
2. Therapeutic recreation staff reports to the leadership structure in fulfilling duties or responsibilities.

B. **PROCEDURE:**

1. Requests for Service:
 - a. All requests for therapeutic recreation services must be in the form of a written prescription from a licensed physician/AHP.
 - b. Verbal requests for therapeutic recreation services will be accepted **for more immediate needs**, but must be followed by a written **order** prescription.
 - c. A new requisition is required for any change in treatment ordered.
2. Hours of Service:
 - a. Inpatient care: Monday through Sunday, 0800 to 1630.
 - i. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities:
 - a. Provides therapeutic recreation evaluations and treatment to rehabilitation unit, behavioral health inpatient unit, and acute care, as prescribed by a licensed physician/AHP.
 - b. Administers appropriate assessments and tests prior to the initiation of treatment.
 - c. **Develops and documents and individualized treatment plan** Provides a written plan for each individual with designated goals, based upon the **patient's** individual's medical condition, age-appropriate considerations **and functional status**, evaluation and test results, and personal **interests** goals.
 - d. Implements initial and ongoing treatment **interventions** programs while maintaining patient privacy. **Treatment includes leisure education to support: skill development in new leisure activities, re-engagement with previous interests, promotion of self-awareness and exploration of meaningful leisure opportunities, support for**

psychosocial adjustment to disability and lifestyle changes through recreational activity. utilizing leisure education that focuses on assisting the patient in learning new leisure skills, redeveloping past leisure skills, and establishing an awareness of self and leisure opportunities. Assists the patient and family in adjustment to disability and a change in lifestyle patterns through the use of recreational activities.

- e.d. Modifies treatment **plan in response to changes in** program based upon medical status, progress/lack of progress, or as requested by the patient's or physician/AHP **recommendations.**
- f.e. In the acute care setting patients will be seen at bedside unless otherwise indicated. Leisure materials may be left for **independent-unsupervised** individual to use, at bedside with nursing **staff** informed of any safety **considerations** concerns and **support** program continuity of care.
- g.f. Documents patient treatment **sessions** and treatment outcomes in patient's **medical record in compliance with documentation standards.**
- h.g. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and **submits** inputs work order.
- i.h. Demonstrates fiscally responsible decision making including **efficient use of time,** the prudent use of therapy **time, therapy** equipment, and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.
- i. Maintains appropriate operational and administrative records; may include but not limited to licensure, certifications, timecards, training records, and billing sheets; as per department guidelines.

REFERENCES:

- C.
1. American Therapeutic Recreation Association (ATRA). (2020). *Standards of Practice for Recreational Therapy & Self Assessment Guide.*
 2. Centers for Medicare & Medicaid Services (CMS). *Conditions of Participation for Hospitals, 42 CFR 482.56 (Rehabilitation Services).* Retrieved from: <https://www.ecfr.gov/current/title-42>
 3. Commission on Accreditation of Rehabilitation Services (CARF). (Current Edition). *Medical Rehabilitation Standards Manual.*
 4. Comprehensive Accreditation Manual for Hospitals: The Official Handbook (EC, PC, and chapters. RC
 5. National Council for Therapeutic Recreation Certification (NCTRC). *Certification Standards for Certified Therapeutic Recreational Specialists.* j-

REHABILITATION CENTER

ISSUE DATE: 12/19 **SUBJECT:** Ethical Code of Conduct

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval:	08/2211/25
Department of Medicine Chiefs Approval:	01/2311/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/2301/26
Administration Approval:	03/2302/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/23

A. POLICY:

1. The Tri-City Rehabilitation Center will adhere to the Tri-City Healthcare District (TCHD) Code of Conduct.
2. Code of Conduct defines ethical practices in patient management that may include altruism, respect and dignity, freedom from abuse/harassment, setting boundaries and restrictions on patient/professional relationships, compassionate care, legal and professional obligations. All clinical staff providing care to rehabilitation patients shall follow the conduct rules and regulations and code of ethics set forth by their professional organization and/or licensing body.

B. RELATED DOCUMENT(S):

1. Tri-City Healthcare District Code of Conduct

C. REFERENCES(S):

1. American Academy of Physical Medicine and Rehabilitation American Nurses Association
2. American Occupational Therapy Association Code of Ethics American Physical Therapy Association Code of Ethics American Psychological Association
3. American Speech and Hearing Association
4. American Therapeutic Recreation Association Code of Ethics National Association of Social Workers
5. National Therapeutic Recreational Society

REHABILITATION CENTER

ISSUE DATE: 12/19 SUBJECT: Interdisciplinary Plan of Care

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval:	08/22 11/25
Department of Medicine Chiefs Approval:	01/23 11/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/23 01/26
Administration Approval:	03/23 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/23

A. **POLICY:**

1. Every patient at the Rehabilitation Center receives a comprehensive individualized treatment program designed to meet the patient's unique needs. Programs are developed jointly by the patient, the family and team of rehabilitation specialists under the direction of the Medical Director (MD), or designee. There shall be evidence of participation from each appropriate rehabilitation discipline in the establishment of an interdisciplinary treatment plan.

B. **PROCEDURE:**

1. The physician will conduct a post-admission evaluation which identifies any relevant changes that may have occurred since the preadmission screening, as well as a review of the patient's prior and current medical and functional conditions and comorbidities in the documented history and physical examination. The post-admission physician evaluation will be completed within the first 24 hours of admission.
2. Nursing will complete their initial nursing assessment and initial goal setting within the first 24 hours of admission.
3. Patients are assessed and treatment initiated within 36 hours of admission by the therapy services (OT, PT, and SLP) that have been ordered by the attending physician.
- 3.4. An initial assessment of the patient by the Social Worker or Case Manager addressing family support, psychosocial factors, and care coordination needs must be completed prior to the first interdisciplinary team conference.**
- 4.5. The Interdisciplinary plan of care is established within 96 hours of admission with input from the interdisciplinary team. The interdisciplinary plan of care coordinated by the physician includes:
 - a. Rehab problem/diagnoses
 - b. Date of onset of injury or illness
 - c. Specific type, number and frequency of services to be rendered by each discipline.
 - d. Address current health status and recommendations for additional resources/consultations necessary to achieve predicted outcomes
 - e. Treatment goals that are realistic, achievable and relevant to the patient
 - f. Measures to assess effects of treatment
 - g. Factors to facilitate and potential barriers for goal achievement
 - h. Individual's (patient's) expressed goals
 - i. Prognosis
 - j. Estimated length of stay
 - k. Discharge planning including expected disposition
 - l. Signature of physician

REHABILITATION CENTER

ISSUE DATE: 12/19 **SUBJECT:** Interdisciplinary Team Conference

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval:	08/22 11/25
Department of Medicine Chiefs Approval:	01/23 11/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/23 01/26
Administration Approval:	03/23 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/23

A. POLICY:

1. Team conferences are held at least biweekly, or as otherwise arranged by the **Acute Rehabilitation Unit (ARU) Liaison/Care**-Coordinator.
2. The conference schedule will be posted on the interdisciplinary schedule.
3. The patients and their family/support system shall be made aware of the interdisciplinary team conference dates.
4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
 - a. Registered Nurse (RN)
 - b. Physical Therapist (PT)
 - c. Occupational Therapist (OT)
 - d. Speech Language Pathologist (SLP)
 - e. Therapeutic Recreation (TR)
 - f. Dietician
 - g. Social Worker **or Case Manager**
 - h. Medical Director (MD)
 - i. **ARU Liaison/Care**-Coordinator
 - i.j. **PPS Coordinator**
5. Summary of Team members' reports are documented directly into the Electronic Health Record (EHR) by physician in attendance at the conference.
6. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
7. Social Worker **or Case Manager** will report to patient/family after the team conference an overall summary of the conference, including functional report, estimated length of stay, and needed equipment.

REHABILITATION CENTER

ISSUE DATE: 12/19 SUBJECT: Mission Statement, Goals and Objectives

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval: ~~08/22~~11/25
Department of Medicine Chiefs Approval: ~~01/23~~11/25
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: ~~02/23~~01/26
Administration Approval: ~~03/23~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/23

A. **POLICY:**

1. Tri-City Rehabilitation Center is an Inpatient Rehabilitation Facility that is dedicated to providing comprehensive, individualized and high quality healthcare to advance the health and wellness of the community we serve.
2. The Inpatient Rehabilitation Facility (IRF) is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.
3. Goals and Objectives:
 - a. To ~~deliver~~ ~~render~~ high quality rehabilitation services to assist each patient in reaching their maximum functional potential, ~~so they may assume their rightful place in society, while learning to live within the limits of their capabilities.~~ **enabling them to reintegrate into society while adapting to their individual capabilities.**
 - b. To enable a patient's safe return to the home or community-based environment upon discharge. ~~The the~~ patient's treatment goals and achievements during an IRF **stay admission** are expected to **demonstrate meaningful and timely advancement toward this outcome.** ~~reflect significant and timely progress toward this end result.~~
 - c. To alleviate pain, restore function, and improve quality of life by using evidence based techniques and approaches in physical, occupational, speech, audiology and therapeutic recreation. These include standardized tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.

REHABILITATION CENTER

ISSUE DATE: 12/19 SUBJECT: Patient/Family Conferences

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval:	08/2211/25
Department of Medicine Chiefs Approval:	01/2311/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/2301/26
Administration Approval:	03/2302/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/23

A. **POLICY:**

1. Patient/family conferences are held as needed to discuss patient progress toward goals and opportunities to maximize patient outcomes.
2. The patients/families will be notified by the **Acute Rehabilitation Unit (ARU) Liaison/Coordinator** ~~Care Coordinator~~ of the date and time of their conference.
3. The conference schedule will be posted on the interdisciplinary schedule.
4. The meeting consists of a brief report from each discipline on the patient's progress, goals, and expected outcomes of rehabilitation stay. Team members reporting include, but are not limited to:
 - a. Registered Nurse (RN)
 - b. Physical Therapist (PT)
 - c. Occupational Therapist (OT)
 - d. Speech Language Pathologist (SLP)
 - e. Therapeutic Recreation (TR)
 - f. Dietician
 - g. Social Worker **or Case Manager**
 - h. Medical Director (MD)
 - i. ~~Care Coordinator~~ **ARU Liaison/Coordinator**
5. Team members' reports are documented on the weekly conference forms.
6. After team reports, the **social worker or case manager** ~~interdisciplinary team~~ meets with the patient and family member to discuss the patient's case.
7. Each discipline will report to the patient and family the progress, goals and expected outcomes of the rehab stay. The team will respond to patient/family questions.
8. Estimated length of stay, discharge plan, needed equipment, and resources are reviewed and modified as needed per the patient's progress. Home evaluation and family/caregiver training if required are reviewed. Discharge date is reviewed and modified as needed.
9. The conferences forms will be placed or scanned into the patient's medical record.

REHABILITATION CENTER

ISSUE DATE: 12/19 **SUBJECT:** Policies and Procedures

REVISION DATE: 12/19, 03/23

Rehabilitation Department Approval:	08/22 11/25
Department of Medicine Chiefs Approval:	01/23 11/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	02/23 01/26
Administration Approval:	03/23 02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/23

A. POLICY:

1. The Tri-City Rehabilitation Center will develop and maintain policies and procedures specific to the Rehabilitation Center when the Hospital (Tri-City Medical Center) policies do not cover necessary regulatory, business, or practice needs.
2. A list of all new, revised, and reviewed Rehabilitation Center Policies and Procedures shall be submitted to Rehab Leadership Team for review and for approval by the Chief Operating Officer. Rehab Policies and Procedures will be submitted according to hospital policy. Interdisciplinary Rehabilitation policies and procedures will be maintained online and be available to staff.
3. Each Rehabilitation Department (Rehabilitation Services, Nursing, Social Services, Case Management, and Diet and Nutrition) shall maintain a departmental Policy and Procedure Manual, which is reviewed and updated in accordance with applicable regulations and Tri-City Medical Center (TCMC) Policy.

- m. Estimated length of stay
- n. Additional needs may include:
 - i. Cultural
 - ii. Dietary
 - iii. Equipment
 - iv. Medications
 - v. Services
- o. Funding
- p. Alternative resources to address additional needs such as hiring caregivers, home modifications, or equipment procurement

REHABILITATION CENTER

ISSUE DATE: 02/20 SUBJECT: Provision of Services Not Provided
by Tri-City Rehabilitation Center

REVISION DATE: 02/20, 03/23

Rehabilitation Department Approval: ~~08/22~~11/25
Department of Medicine Chiefs Approval: ~~01/23~~11/25
Pharmacy and Therapeutics Approval: n/a
Medical Executive Committee Approval: ~~02/23~~01/26
Administration Approval: ~~03/23~~02/26
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/23

A. **POLICY:**

1. Services required that are not provided by Tri-City Rehabilitation Center will be provided through either contracted services or referral to an outside service. Contract services are provided for Physical/Occupational Therapy and Nursing through registry services. Referrals to outside services will be made by a physician and coordinated through ancillary services for the following: Orthotics and Prosthetics, Vocational Rehabilitation, Psychology/Neuropsychology, Dentistry, and Podiatry, **and Audiology.**
2. Contract Services:
 - a. Registry/Traveling Service: To appropriately provide adequate staffing levels, the use of registration and/or traveling contracts may be required. Current contract are maintained and the Registries may be used in the event outside staffing is required to adequately provide quality patient care. As with all contract services, quality of patient care is subject to review.
3. Referral Services:
 - a. Orthotics and Prosthetics Services: Primary services are provided by HANGER. Orthotics and prosthetics representatives consult with Tri-City Rehabilitation Center frequently and actively participate in the department's gait evaluations when needed. Current patients may be fitted prior to their discharge from therapy to monitor fit, proper function, and adequate education of orthosis and prostheses throughout their therapy. The Orthotist/Prosthetist is responsible for documenting any patient interactions and issuing equipment. Referrals to this service may be initiated by Physical or Occupational Therapy; however, a physician's referral is mandatory.
 - b. Psychological/Neuropsychological Services: Referrals for Psychological/Neuropsychological services are made by a physician.
 - c. Vocational Rehabilitation Services: Referrals for Vocational Rehabilitation services are made by a physician. These services are available to our patients through the Department of Rehabilitation in San Diego.
 - d. Dentistry Services: Referrals for Dentistry services are made by a physician.
 - e. Podiatry Services: Referrals for Podiatry services are made by a physician.
 - e.f. **Audiology Services: Referrals for Audiology services are made by a physician.**

REHABILITATION CENTER

ISSUE DATE: 12/19

SUBJECT: Utilization Review Plan

REVISION DATE(S): 12/19

Rehabilitation Department Approval:	05/18 11/25
Department of Medicine Chiefs Approval:	10/19 11/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/19 01/26
Administration Approval:	11/19 02/268
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. POLICY:

1. The purpose of the Tri-City Medical Center (TCMC) **Acute Rehabilitation Unit** Utilization Review (UR) Plan is to review and facilitate the delivery of high quality, safe, appropriate, efficient and effective healthcare services. The program provides an organized, collaborative, system-wide approach to clinical resource management across the continuum of care, and is structured in compliance with The Center for Medicare and Medicaid Services and California Department of Health Services Acute Inpatient Rehabilitation regulations. The Rehab Leadership Team (RLT) is delegated the authority and responsibility to provide oversight, and carry out utilization management and related quality improvement functions.
2. TCMC Rehabilitation Center will differentiate the licensed Inpatient Rehabilitation Facility beds from the Acute Care Services Beds. The TCMC Rehabilitation Center transfers will require a new account number when transferring in and out of TCMC Rehabilitation Center.
3. The UR plan is approved by the Rehab Leadership Team (RLT). The RLT provides oversight and general supervision of the plan. The Medical Director and the **ARU admitting liaison** ~~Director of Case Management~~ are responsible for the development, implementation and maintenance of the UR plan.

B. PROCEDURE:

1. Objectives:
 - a. To review and evaluate admissions to the Inpatient Rehab Facility (IRF) including whether the admission is reasonable and necessary.
 - b. Review and evaluate medical necessity prior to and during the admission.
 - c. To review denials of payments for hospital days and services.
 - d. To evaluate effective use of resources and review departmental outcome data.
 - e. To provide ongoing education and distribute meaningful clinical utilization information regarding individual practice patterns and monitor response.
 - f. To ensure appropriate discharge planning that promotes efficient continuity of care, services, and evaluates delays in discharges.
 - g. Evaluate the effective and efficient use of resources to achieve the goals of the department mission.
2. Utilization Review (**UR**) Committee:
 - a. The UM Committee will meet at minimum monthly. The UM Committee must have representation from **two physicians**. ~~The~~ the following disciplines **may also choose to provide representation:**
 - i. ~~TCMC Rehabilitation Center Medical Director.~~
 - ii.i. Therapy Services Director and/or Manager.
 - iii.ii. **Representative of Director of Case Management.**

- iii. Nursing Manager(s) of inpatient rehab units.
 - iv. **Rehabilitation Psychologist**
 - ~~iv-v.~~ **Representatives from therapy disciplines (PT/OT/SLP)**
 - b. The UR Committee will review charts to ensure approved preadmission -criteria is applied equally to all patients. Review of readmissions, payment denials, length of stay, length of stay efficiency, payer mix, Functional Independence Measure (FIM) change, tier mix, rehabilitation unit census, discharge destination mix, case mix index, short stays, Medicare efficiency, and may include high risk case mix groups and analysis, interrupted stays, disease onset days.
 - c. **Summaries of the utilization review forms are communicated to the staff immediately if necessary, and at the discipline or area specific team meeting on a monthly basis.**
 - d. **Utilization Review summaries are reported to the TCHD Utilization Review Committee monthly and written records remain available for review in electronic format for 3 years.**
 - e. **The Acute Rehabilitation Unit Utilization Review Committee will maintain written records of all its activities. Minutes of the committee meeting shall be documented and will include:**
 - i. ~~The name of the Committee~~**Committee**
 - ii. **The date of each meeting**
 - ~~_____~~iii. **The names of the committee members present and absent**
 - ~~_____~~iv. **A summary of findings, recommendations, and action.**
3. Patient Population:
- a. Due to the complexity of the nursing, medical management, and rehabilitation needs, acute rehab patients require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.
 - b. Each patient assessment and treatment plan must be individualized to the unique care needs of the patient. The treatment plan is developed based on the information from the preadmission screen, the Post-Admission Physician Evaluation, and the information garnered from therapy assessments. The assessment must be synthesized by a rehabilitation physician and completed within 4 days of the IRF admission. At the time of admission, a physician must generate admission orders for the patient's care that must be retained in the patient's medical record at the Inpatient Rehab Facility (IRF).
 - c. The Inpatient Rehabilitation Facility- Patient Assessment Instrument (IRF-PAI) must be contained in the patient's medical record at the IRF. All IRF-PAI documentation and outside facility medical records will be submitted electronically to the TCMC Electronic Medical Record. The information in the IRF-PAI must correspond with all of the information provided in the patient's IRF medical record. IRF Medical Necessity Criteria is as follows:
 - i. Multiple therapy disciplines
 - 1) Intensive rehabilitation therapy program
 - 2) Ability to participate in therapy program
 - 3) Physician supervision
 - 4) Interdisciplinary team approach to the delivery of care
 - ii. For this purpose, "therapy disciplines" include:
 - 1) Physical therapy
 - 2) Occupational therapy
 - 3) Speech-language pathology
 - 4) Orthotics/prosthetics
 - d. All IRF patients must require an intensive rehabilitation therapy program on admission to the IRF. This is demonstrated in IRFs by the provision of therapies at least 3 hours per day with a minimum of 5 days per week, or an average of at least 15 hours per week, and must be documented in the medical record. A week is a 7 consecutive day period starting with the day of admission. Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations may constitute the

initiation of therapy services. Therapy evaluations “count” for the purposes of demonstrating the intensity of therapy requirement.

- e. When the acute medical conditions are of primary importance, the patient belongs in an acute medical licensed bed. When the patient’s rehabilitation needs are of primary importance, the patient may receive care in Tri-City Medical Center (TCMC) Rehabilitation Center. The patient must be medically stable to tolerate at least 3 hours of therapy/day six days per week and be willing to participate in an Acute Rehabilitation Care Plan. If a brief interruption of stay occurs, the reasons for the brief interruption of no more than 3 consecutive days must be well-documented in the patient’s medical record at the IRF.
 - f. Physician visits during an IRF stay are face-to-face visits by the Medical Director, or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the IRF stay.
4. Pre-Admission Screening and Intake Process:
- a. A pre-admission screening evaluation shall be completed for referrals to the Rehabilitation Center. Patients will be evaluated within 24 hours of admission, and an admitting decision will be made based on the established admission criteria. Patients who do not meet the established admission criteria for level of care will be denied admission for inpatient care, or deferred for further evaluation. Admissions to the Rehabilitation Center must be approved by the Medical Director, or designee, for case review.
 - b. The Pre-Screen must be signed by the Admitting Physician within 48 hours prior to admission.
 - c. The Care Coordinator will verify insurance eligibility and obtain authorization to admit, obtain the discharge plan prior to patient admission, coordinate transfer into the Rehabilitation Center, and communicate with the accepting Interdisciplinary Team, and referring facility.
5. Interdisciplinary Team:
- a. The complexity of the patient’s nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to care. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
 - b. The team has the responsibility of assessing the individual’s progress towards the rehabilitation goals; considering possible resolutions to any problems that could impede progress towards the goals; reassessing the validity of the rehabilitation goals previously established; and monitoring and revising the treatment plan, as needed.
 - c. The team shall consist of a minimum of a rehabilitation physician with specialized training and experience in rehabilitation services; registered nurse with specialized training or experience in rehabilitation; social worker or a case manager (or both); licensed or certified therapist from each therapy discipline involved in treating the patient.
6. Impairment Groups Appropriate for Rehabilitation Center:
- a. According to the Rehab Medicare Exemption Criteria from the Medicare PPS, specified in Transmittal 938 at least 60% of the Acute Inpatient Rehabilitation cases shall fall into one of the following categories:
 - i. Stroke
 - ii. Brain Injury
 - iii. Neurologic Disorders
 - iv. Spinal Cord injury
 - v. Systemic vasculidities
 - vi. Amputation
 - vii. Burns
 - viii. Congenital deformity
 - ix. Fracture of femur (Hip fracture)
 - x. Major Multiple Trauma
 - xi. Severe or advanced Osteoarthritis
 - xii. Active polyarticular rheumatoid arthritis, psoriatic arthritis & seronegative arthropathies

xii.xiii. Knee or hip joint replacement that is either bilateral or associated with a BMI >49 or age >84.

7. Medical Necessity for Acute Rehabilitation:
 - a. All patients will continue to be monitored by the interdisciplinary team for the need for a continued stay in TCMC Rehabilitation Center. During the weekly **multidisciplinary team** conference there will **be a** discussion regarding the need for continued stay, and discharge dates and needs. When a patient is no longer requiring the utilization of Inpatient Rehabilitation Facility, the team will collaborate to determine the need for discharge from acute rehab. All discharge needs will be coordinated for the patient with follow up care documented by the team in the Electronic Medical Record.
8. Insurance Denial Management:
 - a. All insured patients will be reviewed at least 1 time per week by the **ARU admitting liaison and the PPS Coordinator** ~~Care Coordinator~~ with the payer source. All denials received regarding TCMC Rehabilitation Center patients will be reviewed by the **ARU admitting liaison, the PPS** ~~Care Coordinator, the and~~ ~~Case Manager/Social Worker, the and the~~ Leadership Team for the Rehab Department, and the Medical Director. The **ARU admitting liaison, PPS Coordinator and Medical Director** will determine if the case warrants and appeal process. If an appeal letter is agreed upon, the Medical Director will complete the required letter, and submit it for reconsideration. This includes appeals from all sources.
9. Confidentiality Policy:
 - a. All UR information and data shall be considered confidential and protected from inappropriate use. Written consent of the patient is required for release of information to persons not otherwise authorized to receive this information. All data and documented review activity submitted to any monitoring agency is in accordance with that organization's confidentiality policy. The patient medical records are the property of the hospital and may not be released from the hospital's jurisdiction and safekeeping except in accordance with court order, subpoena, or statute.
10. **Regulatory Monitoring, Policy Update, and Staff Education:**
 - a. ~~a-~~**The Utilization Review Committee and Rehab Leadership Team will ensure the TCMC Rehabilitation Center's utilization review policy remains current with all applicable CMS and CDPH requirements. The policy will be reviewed annually and updated accordingly, with changes communicated to all relevant staff and reflected in annual policy documentation and staff education sessions. Proposed policy updates will be reported to TCHD Utilization Review Committee. Approved policy updates are appended to the TCHD's Utilization Review Plan.**

Staffing Manual

ISSUE DATE: 12/13 **SUBJECT: Registry Badge Process**

REVISION DATE: 08/15, 07/16, 03/23

Department Approval 09/22/2026
Administration Approval: 03/23
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 03/23

A. **PURPOSE:**

1. It is the policy of Tri-City Healthcare District (TCHD) that all Supplemental Staff are required to wear the TCHD issued identification badge (badge) at all times while present at any TCHD facilities.

B. **POLICY:**

1. Badges must be maintained in good condition. The placement of pins and unauthorized stickers on the badge is prohibited.
2. In no instance should a TCHD issued badge be loaned to someone else or be out of the possession or control of the person the badge was issued to.
3. Violation of this policy may result in discipline in accordance with applicable TCHD Hospitals Human Resource policies.
4. Badges are the property of TCHD and must be returned to the Staffing Resource Office at the end of each shift or upon request.
5. Security has the right to confiscate badges classified as lost, expired or in possession of an individual other than the person to whom the badge is issued.

C. **BADGE DISPLAY:**

1. Supplemental staff must wear the TCMC ID badge at all times while on property owned or under the control of the institution.
2. The badge must be worn on the upper chest and be clearly visible to someone facing the wearer. The badge must be worn horizontally so that patients, guests and fellow employees can easily read it.
3. Badges are non-transferable and are to be used only by the person to whom it is issued.

D. **PROCEDURE:**

1. Registry Staff
 - a. Nursing unit staff will report directly to the ~~staffing~~ Administrative Supervisor office to sign in and obtain a facility badge.
 - b. Registry staff shall wear their TCHD issued badge along with their Registry issued badge with a personal photo displayed.
 - c. Registry RN's will use the TCHD badge with scanning capability for the care of patients.
 - d. Upon completion of the shift, registry staff shall return to the ~~Staffing Resource Office~~ return bin in the ED or the Administrative Supervisor office to ~~sign-out in Shiftwise and~~ return the TCHD issued badge and/or validate paper timecard.
 - e. ~~Staffing~~ **The Administrative Supervisor** Office shall maintain a log of TCHD issued badges and document the checking-out and checking-in of issued badges.

- f. Should Registry Staff not return the TCHD issued badge, the terms of the registry contract shall be enforced and the registry agency notified. Registry staffs are responsible for complying with the TCHD badge process.

2. Traveler Staff

- a. Upon completion of compliance requirements as stated in the contractual agreement with the Travel agency, travelers will obtain a TCHD issued badge from the Employee Health Department.
- b. Traveler will return the badge to the ~~Staffing Office Administrative Supervisor~~ or unit Nursing Leadership of the Department the traveler is assigned to at the end of the ~~assignment~~ **contract** or upon request.

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

- 1. Badge Log Form



PROCEDURE: MONITORING TELEMETRY PATIENTS USING THE DASH 3000

Purpose: To outline the nursing management for Telemetry patients requiring cardiac monitoring or patients with arterial catheters requiring continuous blood pressure (BP) monitoring utilizing the DASH 3000

Supportive Data: The DASH 3000 is used to perform Basic Bedside Monitoring for Telemetry patients

- Equipment:
1. DASH 3000
 2. Monitoring cables for cardiac monitoring, blood pressure monitoring, invasive SpO2 monitoring, and invasive line monitoring if needed
 3. Transducer Holder (if monitoring invasive line)
 4. Electrodes
 5. Pressure Bag
 6. Normal saline
 7. Level

Issue Date: 2006

A. POLICY:

1. ~~Telemetry patients with arterial catheters requiring continuous BP monitoring will be monitored using the DASH 3000 until the arterial catheter is discontinued or as ordered by a physician or Allied Health professional.~~ **Monitoring telemetry patients on the Dash 300 will not be used if a telemetry box is available for use.**
2. The DASH 3000 may ~~also~~ be used for monitoring cardiac rhythms, heart rate, BP, respiratory rate, and oxygen saturation for patients ~~without arterial catheters.~~
3. The DASH may not be used as a vital sign machine for routine vital signs on multiple patients if used as a cardiac monitor for a patient..
4. Only ~~trained~~ **competent** Registered Nurses (RNs) hired for the Telemetry unit and Intensive Care Unit (ICU) staff will be assigned patients **on a Dash.** ~~with invasive line.~~
5. Patients will be monitored using standard monitoring leads in V1 or Lead II. Secondary lead will be based on patient pathology.
6. The primary nurse will verify the patient's rhythm can be viewed on the DASH 3000, the ~~cardiac~~ monitoring screen and the central monitoring station.
 - a. See the Management of Telemetry Patients Policy

B. PROCEUDRE:

1. Admitting a patient:
 - a. Examine DASH to ensure the necessary monitoring equipment is present.
 - b. Notify Monitor Technician (MT) patient will be monitored using the DASH 3000.
 - c. Explain purpose for using DASH 3000 to patient.
 - d. ~~Apply telemetry box to patient.~~
 - e. Turn on DASH by depressing the Green Power button.
 - f. Close initial window using the trim knob located in the lower right-hand corner of the machine. Turning the trim knob left or right identifies all options. Selections are accepted by depressing the trim knob.
 - g. Select More Menus.
 - i. If the previous patient's name is on the screen, select ECG Source, select Discharge Patient, then select both.
 - h. Select Admit Menu.
 - i. ~~Select the Set Unit Name~~
 - i. ~~Select "A Care Unit".~~
 - ii. ~~Scroll down until the arrow points the appropriate unit (IMC 2, IMC 3, or IMC 4).~~

Department Review	Division of Cardiology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/10;2/11, 01/16, 06/20	n/a	n/a	n/a	07/20, 02/26	n/a	02/11, 08/20

- ~~j. Select the patient's bed number.~~
 - ~~k. Select the ECG Source~~
 - ~~i. Number located on the telemetry box.~~
 - ~~ii. Verify correct telemetry box number.~~
 - l. Select the Admit Patient button (patient's name, room number, and rhythm will automatically appear on the main screen).
 - ~~m. If the telemetry box is missing:~~
 - ~~i. Call the MT and use the DASH.~~
 - ~~ii. Admit the patient using the steps outlined a-j.~~
 - ~~iii. Select ECG Source, then select monitor.~~
2. Monitor Setup:
- a. Waveforms On/Off:
 - i. Select main menu or use the trim knob and scroll to ECG.
 - ii. Select ECG Display Lead (If the lead displayed is not II or VI).
 - 1) May select a maximum of three cardiac waveforms which the following lead selections.
 - a) I, II, III, VI, AVR, AVL, AVF.
 - 2) Waveforms may be aligned by selecting "Align Waveforms".
 - 3) The size of a waveform may be increased by selecting "ECG Size".
 - a) The options include: 0.5X, 1X, 2X, and 4X.
 - 4) Other options include:
 - a) Display lead.
 - b) ECG size.
 - c) Detect Pacemaker Mode.
 - d) ECG limits.
 - e) View all ECG.
 - f) Relearn.
 - 5) Select Main Menu or Previous Menu for other options.
 - b. Parameters:
 - i. Select More Menus.
 - ii. Select Parameters On/Off.
 - iii. Turn off the Parameters not being used. i.e., Arterial Line (Art1, Blood Pressure (NBP), SP02, and respiratory rate (RR)). You cannot manually turn off the ECG.
 - c. Setting and Reviewing Alarms:
 - i. Do not pause alarms..
 - ii. Default alarm parameters may be altered at the discretion of the primary RN.
 - iii. Modified alarm parameters will be reset to default settings once patients ECG is within default settings range.
 - ~~1) Communicate to MT alarm parameter changes and provide instructions when to notify primary RN.~~
 - iv. Review alarms history.
 - v. Adjust alarm volumes. Never turn off alarms.
 - d. Patient Data:
 - i. Patient Data includes reviewing information on patient vital signs, alarm history, and dose calculations. Telemetry will not use the dose calculation options.
 - ii. Vital Signs:
 - 1) The vital signs option may be used to select time specific intervals for monitoring non-invasive BP, view recent or older vital signs.
 - 2) To view vital signs in a graph format, select graph setup.
 - 3) Select main menu or previous menu to select more options.
 - iii. Non-Invasive Blood Pressure (NBP) monitoring:
 - 1) Select main menu or use the trim knob to scroll to NBP.
 - 2) Select desires options.

- a) NBP Auto (use this option to set specific time intervals for automatic BP).
 - b) NBP Stat.
 - c) Review NBPS.
 - d) Cuff Size.
 - 3) Select NBP intervals.
 - 4) Select initial inflation pressure.
 - a) Increase the systolic BP (SBP) pressure above default setting for patients with SBPs 160.
 - 5) Select Main Menu or Previous Menu for other options.
 - iv. Respiratory Rate Monitoring:
 - 1) Select RR limits, adjust as needed.
 - 2) Select RR sensitivity, adjust as needed.
 - 3) Select Main Menu or Previous Menu for other options
 - v. SPO2 Monitoring:
 - 1) The following options are available:
 - a) Waveform size.
 - b) Rate, may select on or off.
 - c) Rate Volume.
 - d) SPO2 Limits.
 - 2) Select Main Menu or Previous Menu for other options.
- ~~3. Continuous BP Monitoring for Patients with an Arterial Catheter~~
 - ~~a. Verify orders and attach the tele box (follow all the steps outlined in Admitting a Patient).~~
 - ~~b. Attach transducer holder to an intravenous pole (IV)~~
 - ~~c. Attach the ART Line cable (Red tipped cable) to the DASH in position 1.~~
 - ~~d. Attach the ART line cable to the transducer.~~
 - ~~e. Place transducer into the transducer holder~~
- ~~4. Calibrating (Leveling Arterial Air-Fluid Interface), Troubleshooting, Monitoring and Discontinuing Arterial Catheter:~~
 - ~~a. See Clinical Skills Arterial Catheter Insertion (Assisting), Care and Removal procedure.~~
5. Temporarily Off unit (Pause the DASH when a patient leaves the unit for procedures of diagnostic test):
 - b.a. Attach the patient to a transport monitor as needed or ordered per the physician/AHP.**
 - ~~c.b.~~ Select More Menu
 - ~~d.c.~~ Select Alarm Control
 - ~~e.d.~~ Select Display Off-Alarm Pause
 - ~~f.e.~~ Select monitor/central pause
 - ~~g.f.~~ Disconnect patient (the screen will go blank)
- ~~5.6. Returning to Unit from Procedure:~~
 - a. Reconnect patient to the DASH
 - b. Push trim knob and the patient's cardiac rhythm will appear
 - ~~c. Check monitor at nurse's station to verify patient's rhythm can be viewed by the MT.~~
- ~~6.7. Changing (Discharging) a patient from the DASH 3000 and continuing monitoring using the Telemetry Box:~~
 - ~~a. Select More Menu~~
 - ~~b. Select Admit Menu~~
 - ~~c. Select Discharge Patient~~
 - ~~d. Select Monitor ONLY (this selection changes the monitor to the telemetry box)~~
- ~~7.8. Discharging a patient from both the DASH 3000 and the Telemetry Box:~~
 - ~~a. Select More Menu~~
 - ~~b. Select Admit Menu~~
 - ~~c. Select Discharge Patient~~
 - ~~d. Select Discharge from both~~

8.9. Monitoring the patient:

- a. Monitor the patient per physician orders
- b. Notify the physician as ordered

9.10. Discontinue the Dash 300 when a telemetry box becomes available.

10.11. Patient Education:

- a. Instruct patient and family on the purpose of monitoring patient using the DASH 3000. Instruct patient on activity and positioning restrictions.
- b. Instruct patient to notify nursing for complaints of chest pain, shortness of breath, numbness, tingling, or cool extremities distal to sheath site.
- c. Inform the patient of the signs of bleeding.
- d. Document education provided in the Electronic Health Record.

C. RELATED DOCUMENT(S):

1. Management of Telemetry Patients Policy
2. ~~Arterial Sheath Removal, Femoral Procedure~~

D. EXTERNAL LINK(S):

1. ~~Clinical Skills: Arterial Catheter Insertion (Assisting) Care, and Removal.~~

E. REFERENCE(S):

1. GE Medical Systems Information Technologies. Clinical education and development: Basic bedside monitoring-adult non-invasive parameter.

TELEMETRY UNIT
UNIT SPECIFIC POLICY

ISSUE DATE: -10/11

SUBJECT: Scope of Service

~~ISSUE DATE: 10/11~~

REVISION DATE(S): 10/11

Department Approval:	08/25
Division of Cardiology Approval:	12/25
Pharmacy and Therapeutics Approval:	na
Medical Executive Committee Approval:	01/26
Administration Approval:	02/26
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/11

A. PURPOSE:

1. To ensure Telemetry monitored beds are available and used appropriately to meet patient care needs.
2. To ensure adequate and competent surveillance of cardiac support equipment.
3. To ensure adequate numbers of trained responders to expeditiously treat life-threatening conditions.
4. To provide individualized quality patient care in a safe environment.
5. To reduce complications and unexpected outcomes.
6. To continuously evaluate and improve the service provided.
7. To participate in interdisciplinary care by working closely with other disciplines.

B. BRIEF DESCRIPTION OF SERVICE:

1. Telemetry ~~is a 680 bed~~ **has the capacity for 80 cardiac monitored patients** ~~monitoring unit located on 23 floors on the South Tower, and 3 Pavilion.~~
2. The South Tower has 450 private rooms and 4108 double occupant rooms; east and west; **on the 2nd and 4th floor** each unit accommodates 12 patients. 3 ~~East Pavilion~~ **has 810 private rooms and 62 double occupant rooms; one of the private rooms is a negative pressure room.** Telemetry provides care for patients with cardiac medical and/or surgical diagnoses for inpatients and observation patients. The Telemetry staff includes Registered Nurses (RN), Advanced Care Technicians (ACT), Monitored Technicians (MT), ~~Lift Team Technicians (LTT), Unit Secretaries (US), Charge Nurses Assistant Nurse Managers (ANM), a Clinical Educator, and a Clinical Nurse Manager.~~

C. METHODS USED TO ASSESS PATIENTS' NEEDS POLICY:

1. Admission, initial shift assessments, reassessments, and systemic specific assessments are performed by RNs per the Standards of Patient Care. Nurses utilize a variety of sources to gather pertinent information i.e., physical assessment, data from the patient's medical record, patient, families or significant others, and other disciplines.

D. SCOPE AND COMPLEXITY OF SERVICES:

1. Services provided include a variety of conditions/presentations of a stable nature with the potential to become unstable requiring cardiac monitoring less intensive monitoring and care provision than an Intensive Care Unit (ICU).
2. The unit provides services for patients with cardiac medical and/or surgical diagnoses including but not limited to the following; coronary artery disease, acute coronary syndrome, myocardial infarction, heart failure, cardiomyopathies, pre and post cardiovascular surgery, temporary

transcutaneous and epicardial pacing, pre and post coronary interventions, acute and chronic renal failure, arterial and central venous pressure monitoring and patients requiring the initiation and management of **medications**; oral and intravenous anti-dysrhythmics, ~~vasoactives~~**vasoactive**, antithrombins, antiplatelet inhibitors, phosphodiesterase and vasodilator therapy. The unit also provides care for respiratory patients requiring endotracheal and tracheal ventilator support and BiPAP, ischemic and hemorrhagic strokes, vascular surgeries, and observation stays. See Telemetry Unit Specific Policy Admission Discharge Criteria.

3. Telemetry is inappropriate for the following patients: hemodynamic instability; ongoing suggestive of myocardial ischemia or symptoms not resolved with treatment; monitoring of more than one femoral line; thrombolytic therapies (~~tPA, Streptokinase, Urokinase~~), vasopressors requiring titration and medical or surgical patients not requiring cardiac monitoring or Telemetry unit specific care.
4. The nursing services are coordinated with other disciplines and integrated in the interdisciplinary care and treatment of the patients. Areas in the nursing assessment, if appropriate, trigger screenings for other departments including but not limited to Dietary, Social Service, Case Management, Respiratory, Occupational Therapy, Physical Therapy, and Speech Therapy.

E. **PATIENT POPULATION TYPE AND AGES:**

1. The unit provides services for adolescents age 14 to adults.

F. **STAFFING AND THE AVAILABILITY OF STAFF-**

1. **A Nurse Director has oversight of the Telemetry service and collaborates with the leadership and staff.**
- 4.2. The unit is staffed with a Clinical **Nurse** Manager (CNM), **Assistant Nurse Manager (ANM), Charge Nurses**~~Assistant Nurse Managers (ANM), RNs, Advanced Care Technician Assignment Nurse~~break relief RNs, **(ACT)Ts, Monitor Technician (MT) s,** and ~~LTT~~ **Unit Secretary (s,** and US); a relief charge RN is assigned when ANMs are not scheduled. The Clinical **Nurse** Manager has 24-hour responsibility for patient care and unit management. All of the staff scheduled for 12-hour shifts. ~~excluding the CM & Clinical Educator. The unit secretaries are scheduled for 8 and 10-hour shifts.~~
- 2-3. The unit is staffed and patients are assigned using hospital staffing guidelines, California staffing ratios and the Synergy **Nursing** Model.
- 3-4. The **ANM/ANM** or relief charge RN ensure staff assignments are selected according to patient acuity, staff availability, individual staff competencies, and the amount of supervision required by staff.
- 4-5. Basic Life Support (BLS) certification is required for the RNs, **and** ACTs,~~and LTTs~~. Advanced Cardiac Life Support (ACLS) certification and National Institute of Health Stroke Scale (NIHSS) certification is required for all RNs. **Clinical Nurse Manager ANMs** and the Clinical Educator are required to obtain Progressive Care Certified Nurse (PCCN) **or Critical Care Registered Nurse (CCRN)**. All RNs, **and** ACTs,~~and LTTs~~ must complete an annual Skills Lab.

G. **ASSESSING DEPARTMENT SERVICES:**

1. The unit services are provided 24-hours a day, 7-day-a-week. When a patient requires a higher level of care, physicians and nursing staff coordinate the transfer to the ICU or an appropriate facility with assistance of case management.

H. **THE EXTENT TO WHICH THE DEPARTMENT'S LEVEL OF CARE/SERVICE MEET PATIENT NEEDS:**

1. The level of care provided by the Telemetry unit meets the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with other disciplines.

I. **PERFORMANCE IMPROVEMENT:**


1. The unit uses the Find Organize Clarify Understand Select - Plan Do Check Act (FOCUS-PDCA) and GEMBA methodologies for process improvement.

J. **STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:**

1. The nursing service abides by regulations by California Title XXII, Title 16, The Joint Commission, Board of Registered Nursing (BRN), and Centers for Medicare and Medicaid Services (CMS). Clinical Practice Guidelines for specific patient population i.e., Community Acquired Simple Pneumonia, Heart Failure

K. **MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:**

1. Medications, general and narcotics, are dispensed via the Pyxis system. Intravenous maintenance solutions and normal saline flush solutions are stored in a supply Pyxis located near the medication Pyxis. Medications requiring refrigeration are stored at the appropriate temperatures. Medications that are not dispensed by the Pyxis system are stored in locked cabinets. Nurses assess and document the administration, effectiveness, and side effects of medication per the Medication Administration Policy.

 Tri-City Medical Center	TELEMETRY
PROCEDURE:	WEIGHING TELEMETRY PATIENTS
Purpose:	To identify the Telemetry patient populations requiring admission, daily and weekly weights
Supportive Data:	Admission weight is a baseline for establishing fluid volume status, nutritional status status , and medication administration. Daily weights are used in fluid management and are important until the weight stabilizes at a dry weight. Weekly weights are used for tracking body weight i.e. muscle or fat. Obtaining accurate weights requires outlining a set time of day for weighs, ensuring the patient wears the same clothing, and the use of the same scale. A weight gain of 1 (one) kilogram in 24 hours represents 1000 mL (1 liter) of additional fluid retention.
Equipment:	Scale: bed scale, chair scale, standing scale, or Lift Equipment Hoyer lift .
Issue Date:	12/09

A. POLICY:

1. The primary Registered Nurse (RN) shall ensure all patients admitted to Telemetry are weighed on arrival to the unit in kilograms.
 - a. A physician's order is not required.
 - b. Stated weights are not acceptable.
2. Patients transferred to Telemetry from departments other than the Intensive Care Unit (ICU) shall be weighed as soon as possible after arrival to the unit, if not weighed on admission or if admission weight is greater than 3 days.
3. Daily and weekly weights shall be obtained and documented in the Electronic Health Record (EHR) by 0600 using the same scale.
4. **It is recommended** All patients ~~are~~ shall be weighed using a chair scale unless contraindicated.
 - a. ~~If it is contraindicated to use a chair scale use a bed scale, Hoyer lift scale or standing scale may be used~~
5. All beds with scales shall be zeroed per manufacturers' recommendation prior to the patient's arrival to the unit and ~~when~~**after** bed is cleaned after a patient is discharged or transferred.
6. **The primary nurse or Advanced Care Technician (ACT) shall be present in the patient's room when the following patients are weighed:**
 - a. **Ventilator patients**
 - b. **Trached patients**
 - c. **Patients with central venous lines**
- 6.7. The following patients shall be weighed daily and RNs shall use the following table as a guide to place patients on fluid restriction or as per physician order. ~~Advanced Care Technicians (ACTs)~~ will post fluid restriction or fluid limit signage as directed by the primary RN.-.

Diagnosis	Fluid Restriction
Acute Renal Injury	Fluid restriction may not be required for this patient population. Restrict fluids as ordered by the physician.-
Renal Failure on Dialysis	Fluid restriction per physician's order. If no orders exist, the RN shall ask the patient for their home fluid restriction value or request an order from the physician.
Heart Failure	Fluid restriction per physician's order. If no orders exist, fill water patient's pitcher with 500 mL per shift.

Department Review	Division of Cardiology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
8/10, 2/11, 08/15, 08/25	01/16, 12/25	n/a	01/16, 01/26	02/26	03/16, n/a	03/16

Post-operative Cardiovascular Surgery	Fluid restriction per physician's order. If no orders exist, fill water patient's pitcher with 500 mL per shift.
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- 7.8. Patients receiving the following treatments shall be weighed on Sunday or Monday prior to 0600. See the Standards of Care for Adults
- a. Long term ventilators
 - b. Patients receiving Total Parental Nutrition (TPN), and/or Tube Feedings
- 8.9. The primary RN is responsible for ensuring weights are completed and documented accurately.
- 9.10. The primary RN is responsible for reviewing daily weights entered in the EHR by ACTs or Registry Certified Nursing Assistants (CNA)/Nursing Assistants (NA) ~~—prior~~ **prior** to the end of their shift for discrepancies. If the patient's weight is equal to or exceeds 1 kg in 24 hours perform the following interventions:
- a. Ensure the patient was weighed as outlined in this procedure.
 - b. Review patient's intake and output.
 - c. Reassess the patient for signs and symptoms of fluid overload i.e. change in respiratory status, changes from previous pulmonary assessment, positive fluid balance, new or increased edema.
 - i. Document reassessment in the EHR.
 - d. After validating the weight entered in the EHR.
 - i. Inform the oncoming RN during hand-off.
 - 1) The oncoming RN will discuss the weight and possible changes in orders with a physician.
 - e. The lift team shall be notified as needed to assist with weights.
 - f. ACTs and/or CNAs/NAs are responsible for entering accurate values in the EHR.

B. WEIGHING A PATIENT USING A CHAIR SCALE:

1. Place pillow case in seat of chair.
2. Zero chair scale in kilograms.
3. Ensure patient removes personal clothing (underwear may be worn).
4. Assist patient into a hospital gown and skid proof slippers.
5. Assist patient to chair scale.
6. Remove or hold Telemetry box away from patient.
7. Ensure foley catheters, rectal tubes have been emptied, if present.
8. Press the weigh button.
9. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
10. Document the patient's weight in the EHR and document "Chair Scale" in the comments.
11. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

C. WEIGHING A PATIENT USING THE STANDING SCALE:

1. Zero scale in kilograms.
2. Ensure patient removes personal clothing (underwear may be worn).
3. Assist patient into a hospital gown and skid proof slippers.
4. Assist patient to scale.
5. Remove or hold Telemetry box away from patient.
6. Ensure foley catheters, rectal tubes have been emptied, if present.
7. Press the weigh button.
8. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
9. Document the patient's weight in the EHR and document "Standing Scale" in the comments.
10. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

D. WEIGHING A PATIENT USING THE BED SCALE:

1. Use the bed scale only if contraindicated.

2. Ensure bed scale has been zeroed. If unsure, refer topic Zeroing a Bed Scale in this policy.
3. Lower head of bed; bed must be flat prior to weighing patient.
4. Ensure patient removes personal clothing (underwear may be worn).
5. Remove additional patient equipment from bed and/or bed frame i.e. compression stockings, ventilator tubing, additional pillows and/or blankets, wound vac, constavac etc.
6. Remove or hold Telemetry box away from patient.
7. Ensure foley catheters, rectal tubes have been emptied, if present or hold away from bed.
8. Press the weigh button per manufacturers' recommendations.
9. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
10. Document the patient's weight in the EHR and document "Bed Scale" in the comments.
11. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

E. **WEIGHING A PATIENT USING LIFT EQUIPMENT A HOYER LIFT:**

1. ~~The primary nurse or ACT shall be present in the patient's room when the following patients are weighed:~~
 - a. ~~Ventilator patients~~
 - b. ~~Trached patients~~
 - c. ~~Patients with central venous lines~~
 - d. ~~Patients with multiple equipment~~
2. ~~Follow the manufacturer instructions for performing weights. The primary nurse shall ensure the following:~~
 - a. ~~The Hoyer lift is zeroed using the sling, patient gown and one top sheet.~~
 - b. ~~Telemetry box is removed or held away from patient.~~
 - c. ~~Foley catheters, rectal tubes have been emptied, if present.~~
 - d.1. ~~Tubing(s) are lifted from sling.~~
 - 3.2. Temporarily document the patient's weight on the vital signs worksheet or your report sheet.
 - 4.3. Document the patient's weight in the EHR and document **the type of lift equipment used** "Hoyer Scale" in the comments.
 - 5.4. If previously weighed, compare weights. If a discrepancy exists, follow the steps outlined in this procedure.

F. **ZEROING A BED SCALE:**

1. All beds with scales shall be zeroed per manufacturers' recommendation prior to the patient's arrival to the unit and after bed is cleaned post transfer or discharge.
2. Zero bed scale prior to placing a patient in the bed as follows:
 - a. Lower head of bed; bed must be flat prior to zeroing.
3. Raise upper side rails.
4. Zero bed with the following linen:
 - a. One flat sheet
 - b. One fitted sheet
 - c. One blanket (do not use bath blankets)
 - d. One pillow
 - e. One pillow case
 - f. One patient gown
 - g. One draw sheet, **slider sheet**, or paper chux
5. ~~Write on patient board "Bed Zeroed, the date and time.~~

G. **REFERENCE LIST:**

1. ~~Elsevier Performance Manager Clinical Skills. (2019). Admission. Mosby's Skills. (2006-2014). Admission, 2014. Retrieved from TCMC Intranet~~
2. Tri-City Hospital District Standards of Care for Adults. Retrieved from TCMC intranet.
3. ~~Urden, L.D., Stacy, K.M., & Lough, M.E. (2014). Critical care nursing: Diagnosis and management. (7th ed.). Elsevier St. Louis: MO.~~

ULTRASOUND AND VASCULAR IMAGING

ISSUE DATE: 05/11

SUBJECT: How to Report a Critical/Stat Read

REVISION DATE: 01/18

Ultrasound Department Approval:	09/2410/25
Department of Radiology Approval:	12/2212/25
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/2301/26
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/23

A. **DEFINITION(S):**

1. A critical result is identified as a result that changes the management of patient care. Some examples are deep vein thrombosis, ectopic, or pseudo-aneurysm.

B. **POLICY:**

1. After scanning a patient and speaking with a radiologist to confirm that it is a critical read the sonographer must contact the referring physician for further instruction.
2. A phone call will be placed to the referring physician office explaining the results and requesting further instructions for the patient.
3. The sonographer must document the phone call. Make sure the date, time and person the sonographer spoke to are documented on the requisition under the "critical results" area.
4. The sonographer will complete the exam in ~~Cerner~~ **the Electronic Medical Record and McKesson and Picture Archiving Communication Archiving Communication system** and scan in the documented critical results requisition.
5. The sonographer will speak with the patient regarding the instructions from the referring physician.
6. The Sonographer will scan the paperwork into ~~McKesson~~ **Picture Archiving Communication System** and then shred the paperwork.

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

January 26, 2026 – 4:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 4:00 p.m. on January 26, 2026.

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

Director Sheila Brown
Director Nina Chaya, M.D.
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Tracy M. Younger

Absent were Directors Coulter and Sanchez

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeremy Raimo, Chief Operations Officer
Donald Dawkins, Chief Nurse Executive
Anh Nguyen, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Mark Albright, Chief Information Officer
Jennifer Paroly, President, Foundation
Eva England, VP/Ancillary Services
Mohammad Jamshidi-Nezhad, D. O., Chief of Staff
Robert S. Lee, M.D., Chief of Staff Elect
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 4:00 p.m. with attendance as listed above.
2. Approval of Agenda

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

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

Chairperson Younger made an oral announcement of the item listed on the January 26, 2026 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report Involving Trade Secrets.

4. Motion to go into Closed Session

It was moved by Director Gleason and seconded by Director Brown to go into Closed Session at 4:05 p.m. The motion passed with Directors Coulter and Sanchez absent (5-0-0-2).

5. At 5:00 p.m., the Board returned to Open Session with attendance as previously noted.
6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott reported the Board met in Closed Session and heard a report involving trade secrets pursuant to Health & Safety Code 32106 and took no action.

7. Presentation and discussion of True North Research Community Survey related to Tri-City Healthcare District and Sharp Healthcare Lease Affiliation; and next steps on public information and election communications from CliffordMoss.

Bonnie Moss, Principle with Clifford Moss discussed a comprehensive Public Engagement and Election Readiness Plan to support the Board's consideration of a proposed 30-year partnership with Sharp HealthCare. This agreement, which would authorize Sharp to lease and operate Tri-City Medical Center and related facilities, requires voter approval in the June 2, 2026 election. The District is currently in the Public Engagement and Awareness phase, running through March 6, 2026, focused on providing factual, transparent information to the community while preparing for ballot qualification. Communications emphasize the evolving healthcare landscape, the strategic rationale for partnering with Sharp, and the requirement for majority voter approval. All engagement activities adhere strictly to legal guidelines, ensuring District resources are used solely for informational purposes. Once the election window opens, advocacy activities will transition to volunteer-led efforts conducted independently of District operations.

8. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 6:00 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

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

January 29, 2029 – 2:30 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:30 p.m. on January 29, 2026.

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

Director Sheila Brown
Director Nina Chaya, M.D.
Director Rocky J. Chavez
Director George W. Coulter
Director Gigi S. Gleason
Director Tracy M. Younger

Absent was Director Sanchez

Also present were:

Gene Ma, M.D., Chief Executive Officer
Anh Nguyen, Chief Financial Officer
Mohammad Jamshidi-Nezhad, D. O., Chief of Staff
Robert S. Lee, M.D., Chief of Staff Elect
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

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

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

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

Chairperson Younger made an oral announcement of the items listed on the January 26, 2026 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, Report Involving Trade Secrets, Hearings on Repots of the Hospital Medical Audit or Quality Assurance Committees, and Public Employee Evaluation: C-Suite.

4. Motion to go into Closed Session

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

5. At 3:29 p.m., the Board returned to Open Session with attendance as previously noted.
6. Report from Board Counsel on any action taken in Closed Session.

Board Counsel Scott stated he would give a report regarding any action taken in Closed Session at the beginning of today's open session.

7. Adjournment

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

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

**TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
January 29, 2026 – 3:30 o'clock p.m.**

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on January 29, 2026.

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

Director Sheila D. Brown
Director Rocky Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Tracy M. Younger

Absent was Director Sanchez

Also present were:

Dr. Gene Ma, Chief Executive Officer
Donald Dawkins, Chief Nurse Executive
Jeremy Raimo, Chief Operating Officer
Anh Nguyen, Chief Financial Officer
Mark Albright, Chief Information Officer
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, President, Foundation
Mohammad Jamshidi-Nazhad, D. O., Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

Chairperson Younger called the meeting to order at 3:30 p.m. with attendance as listed above.

1. Report from Closed Session

Board Counsel Scott reported the Board in Closed Session conferred with legal counsel concerning the O'Neill, Devin Murria as Successor in Interest for Elizabeth Camp vs. Tri-City Healthcare District, Case No. 24CU024254N and directed counsel to take appropriate action to settle to case.

The Board also discussed the Tri-City Healthcare District vs. Medical Acquisition Company, Case No. 37-2020-00022703-CU-BC-NC and took no action.

The Board also heard a report involving Trade Secrets pursuant to Health & Safety Code 32106 and took no action.

The Board also heard a report involving Quality Assurance pursuant to Health and Safety Code 32155 and took no action.

Finally, the Board conducted an Employee Evaluation of the Hospital C-Suite employees pursuant to Government Code Section 54957 (b)(i) and took no action.

2. Pledge of Allegiance

Director Chavez led the Pledge of Allegiance.

3. Approval of Agenda

It was moved by Director Gleason and seconded by Director Brown to approve the agenda as presented. The motion passed (7-0-0-1) with Director Sanchez absent.

4. Public Comments – Announcement

Chairperson Younger read the Public Comments section listed on the January 29, 2026 Regular Board of Directors Meeting Agenda.

5. Executive Reports

Jeremy Raimo, COO reported on the following:

Tri-City's psychiatric facility is now open and treating patients although not yet at full capacity during final modifications.

The emergency department construction is complete and awaiting state approval, with plans for grant-funded upgrades to ensure consistent patient experience across all stations.

The new OBGYN clinic begins a soft opening next week for urgent post-op and late-term visits, ramping up fully afterward.

Dr. Christopher Bo, a newly recruited spinal cord injury specialist, has already treated and discharged 15 complex patients from acute rehabilitation, surpassing historical volumes and advancing plans for a spinal cord center of excellence. At the same time, Tri-City's Blue Distinction Center designation for spine and joint care has driven spine surgery volumes to a 10-year high, with consistently excellent outcomes.

Donald Dawkins, CNE, reported that Dr. Ma's leadership has strengthened teamwork, transparency, and accountability, producing measurable gains in clinical quality, operations, and patient experience. Cardiovascular surgery volume rose 13% (87 to 100 cases), advanced heart-pump cases increased 44% (18 to 32), TAVR volume remained strong at 48, and ED boarding time was cut nearly in half (6.9 to 3.6 hours).

Workforce development has been a major success, with 226 new staff (including 152 RNs and 42 new graduates), over 313 students rotating through the hospital, RN attrition held at 14% versus 18.3% nationally, and an estimated \$4–6 million in annual savings.

The stroke program has achieved national recognition as a thrombectomy-capable center, with high activation volumes, superior reperfusion rates, and outcomes exceeding American Heart Association benchmarks.

Patient experience has also improved sharply, with top-box scores up about 50% and percentile rank rising from 1st to 23rd, with a trajectory toward the 50th percentile by June and a 75th-percentile goal by winter 2027.

Jennifer Paroly, Foundation President, reported that the Foundation has contributed almost \$3 million thus far this fiscal year toward its \$8 million commitment and expects to come close to the full amount, depending on pending projects. She noted that the ED remodel is nearing completion, with an additional \$1.2 million in approved costs, and the Foundation aims to increase the net grant to support this work.

7. December, 2026 Financial Statements – Anh Nguyen, Chief Financial Officer

Anh Nguyen, CFO reported on the current and fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – \$29,251
- Operating Expense – \$30,468
- Total Non-operating Revenue (Expenses) \$1,452
- EBITDA – \$1,747
- EROE – \$234

Anh reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – \$172,225
- Operating Expense – \$180,632
- Total Non-Operating Revenue (Expenses) \$12,616
- EBITDA – \$13,142
- EROE – \$4,209

Key Indicators – FYTD include:

- Average Daily Census – 121.8
- Average Acute Length of Stay (ALOS) – 4.91
- Adjusted Patient Days – 40,227
- Surgery Cases – 2,518
- ED Visits – 24,347

Anh also presented graphs including Average Daily Census, Acute Average Length of Stay and Productive Full Time.

Director Chavez left the meeting at 4:06 p.m.

8. Special Presentation –

Tri-City Medical Center honored a local Oceanside Pop Warner team that traveled to North Carolina and won the Pop Warner Football National Championship, with financial support from Tri-City. Coaches, families, and players expressed heartfelt gratitude and praised Tri-City's role in supporting youth beyond healthcare. The team presented a championship jersey to Dr. Ma, which he accepted on behalf of the Tri-City community. Board members voiced pride in how the players represented Oceanside.

9. New Business

- a) Consideration to approve an agreement with the Center for Neurohealth Inc., dba, Salma Health (Mohammed Ahmed, M.D.) for the co-medical directorship of the Outpatient Behavioral Health – Morning and Afternoon Program.

Sarah Jayousi, Manager for Behavioral Health explained the proposed contract will replace one of the program's retiring physicians, in order to ensure continued physician coverage and program operations.

It was moved by Director Brown to approve an agreement with the Center for Neurohealth, Inc., dba, Salma Health (Mohammed Ahmed, M.D.) for the co-medical directorship of the Outpatient Behavioral Health Morning and afternoon program for a term of 17 months, beginning February 1, 2026 and ending June 30, 2027, for an hourly rate of \$165, an annual cost of \$87,120 and a total term cost of \$123,420. Director Coulter seconded the motion.

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

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

- b) Consideration to approve an independent physician recruitment agreement with Muhammad Madkour, M.D., Interventional Cardiology physician to practice in the communities served by the district.

Jeremy Raimo, COO presented a physician recruitment agreement with interventional cardiologist Dr. Mohammad Madkour, who is completing his fellowship at UCSF Fresno and will join Heart Care Associates expanding Tri-City's heart care capacity. The proposal is for a two-year agreement and three-year forgiveness period creating an effective five-year commitment to the community.

Director Sanchez joined the meeting at 4:15 p.m.

It was moved by Director Brown to approve an expenditure, not to exceed \$1,045,000 to facilitate the addition of Muhammad Madkour, M.D. Interventional Cardiology physician, to practice in the communities served by the district (not to exceed a two-year income guarantee with a three-year forgiveness period) between Tri-Tri-City Healthcare District and Muhammad Madkour, M.D. Director Gleason seconded the motion.

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

AYES:	Directors:	Brown, Chaya, Coulter, Gleason, Sanchez and Younger
NOES:	Directors:	None
ABSTAIN:	Directors:	None

ABSENT: Directors: Chavez

- c) Consideration to approve market rate adjustment for employees not under contract for collective bargaining agreements.

Dr. Ma presented a compensation proposal that underscores the organization's commitment to its people and includes an additional market rate adjustment for non-union employees, building on a performance-based market increase implemented in November to maintain competitive and fair pay.

It was moved by Director Brown to approve a 4% market rate adjustment for employees not under contract for collective bargaining agreements. Director Coulter seconded the motion.

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

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

9. Old Business - None

10. Chief of Staff

- a. Consideration to approve the January 2026 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on January 26, 2026.

It was moved by Director Gleason to approve the January 2026 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on January 26, 2026. Director Coulter seconded the motion.

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

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

11. Consideration of Consent Calendar

It was moved by Director Brown to approve the Consent Agenda as presented. Director Coulter seconded the motion.

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

AYES:	Directors:	Brown, Chaya, Coulter, Gleason, Sanchez and Younger
NOES:	Directors:	None

ABSTAIN: Directors: None
ABSENT: Directors: Chavez

12. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

13. Comments by Members of the Public

Chairperson Younger recognized Clinical Nurse Manager, Joshua Smiley, who reported on patient rounding and the positive feedback received.

Chairperson Younger recognized Joanne Barnett, Sr. Nurse Director who commented on the reinstatement of Assistant Nurse Manager roles.

14. Comments by Chief Executive Officer

Dr. Ma recognized Security Manager, Tim Viers and wished him a happy birthday, praising him as someone who embodies the values Tri-City is so proud of.

15. Board Communications

Board Chairperson Younger invited everyone to a special meeting next Thursday, February 5th at which time the Board will consider a resolution to place the proposed affiliation with Sharp on the June 2nd ballot for voter approval.

Director Brown acknowledged Joshua Smiley for the good work around the patient experience.

16. Adjournment

There being no further business Chairperson Younger adjourned the meeting at 4:25 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

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

February 5, 2026 – 4:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 4:00 p.m. on February 5, 2026.

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

Director Sheila Brown (Via teleconference)
Director Nina Chaya, M.D.
Director Rocky J. Chavez
Director Gigi S. Gleason
Director Adela I. Sanchez
Director Tracy M. Younger

Absent was Director Coulter

Also present were:

Gene Ma, M.D., Chief Executive Officer
Jeremy Raimo, Chief Operations Officer
Donald Dawkins, Chief Nursing Officer
Anh Nguyen, Chief Financial Officer
Roger Cortez, Chief Compliance Officer
Mohammad Jamshidi-Nezhad, D. O., Chief of Staff
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. Chairperson Younger called the meeting to order at 4:00 p.m. with attendance as listed above.
2. Approval of Agenda

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

3. Public Comments Announcement

Chairperson Younger read the Public Comments section listed on the February 5, 2026 Special Board of Directors Meeting Agenda.

4. Consideration to approve Resolution 831, A Resolution of the Tri-City Healthcare District Board of Directors Ordering a Measure Relating to the Approval of the Lease and Affiliation with Sharp HealthCare and Tri-City Medical Center Corporation Be Placed on the Ballot and Requesting that The Board of Supervisors of San Diego County Consolidated the Measure with Such Other Measures as Called for on the June 2, 2026 Primary Election

Board Counsel Jeff Scott presented the resolution, noting that it reflects the due diligence and public meeting process undertaken by the Board, including approval of the affiliation documents on December 11, 2025. The resolution includes the ballot measure text,

requests designation of the measure as "Measure H," and requires reimbursement to the County for election costs.

There were no public comments.

It was moved by Director Chavez to approve Resolution No. 831 Ordering a Measure Relating to the Approval of the Lease and Affiliation with Sharp HealthCare and Tri-City Medical Center Corporation Be Placed on the Ballot and Requesting that The Board of Supervisors of San Diego County Consolidate the Measure with Such Other Measures as Called for on the June 2, 2026 Primary Election

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

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

Director Coulter joined the meeting at 4:10 p.m.

5. Closed Session

Chairperson Younger announced the Board would be adjourning to closed session.

6. Motion to go into Closed Session

It was moved by Director Gleason and seconded by Director Chaya to go into Closed Session. The motion passed unanimously (7-0).

7. At 5:00 p.m. the Board returned to open session with all Board members present.

8. Report after Closed Session

Board Counsel Scott the Board in closed session considered a report related to public employee evaluations of the C-suite employees pursuant to government code section 54957(b)1 and took no action.

9. Adjournment

There being no further business, Chairperson Younger adjourned the meeting at 5:05 p.m.

Tracy M. Younger
Chairperson

ATTEST:

Adela I. Sanchez
Secretary

Building Operating Leases
 Month Ending January 31, 2026

Lessor	Sq. Ft.	Base Rate per Sq. Ft.	Total Rent per current month	Lease Term		Services & Location	Cost Center
				Beginning	Ending		
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	\$3.59 (a)	58,139.34	07/01/17	06/30/27	OSNC - Carlsbad 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 V#83204	Approx 10,218	\$2.58 (a)	42,157.32	07/01/17	08/31/26	OSNC - Oceanside 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	\$2.70 (a)	20,594.69	07/01/20	06/30/30	PCP Clinic Vista 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 V#84195	Approx 4,995	\$2.50 (a)	23,026.37	10/01/22	06/30/27	OSNC - Vista 1958 Via Centre Drive Vista, Ca 92081	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 2,460	\$2.21 (a)	8,511.41	04/01/23	03/31/26	La Costa Urology 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Approx 4,508	\$1.75 (a)	13,741.04	05/14/21	10/31/31	Seaside Medical Group 115 N EL Camino Real, Suite A Oceanside, CA 92058	7094
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	\$4.00 (a)	26,640.96	09/01/21	08/31/33	PCP Clinic Carlsbad 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	\$1.67 (a)	14,503.49	07/01/21	06/30/26	Outpatient Behavioral Health 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	\$4.12 (a)	34,420.00	10/01/22	09/30/29	North County Oncology Medical Clinic 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	\$3.45 (a)	15,786.75	06/01/21	05/31/26	OSNC Encinitas Medical Center 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
BELLA TIERRA INVESTMENTS, LLC 841 Prudential Dr, Suite 200 Jacksonville, FL 32207 V#84264	Approx 3,262	\$2.21 (a)	11,556.77	05/01/23	04/30/26	Pulmonary Specialists of NC 3907 Waring Road, Suite 2 Oceanside, CA 92056	7088
Sycamore Ave II LLC 3121 Michelson Drive, Suite 500 Irvine, CA 92612 V#84682	Approx 2,912	\$3.00 (a)	23,994.88	02/01/26	05/31/31	North County Women's Specialist 902 Sycamore Avenue, Suite 203 Vista, CA 92081	7075
Total			293,073.02				

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

Education & Travel Expense
Month Ending January 2026

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6171	ONS/ONCC CHEMO IMMUNOTHERAPY (Summ trans)	010626	325.00	999051019	TARA PADHI
6171	ONS/ONCC CHEMO IMMUNOTHERAPY (Summ trans)	100725	325.00	999051025	MARGARITA BARHAM
6185	ONS/ONCC CHEMO-IMMUN THERAPY (Summ trans)	111225	325.00	999051011	JENNIFER MCLEAN
6185	ONS CANCER BASICS (Summ trans)	111225	227.00	999051011	JENNIFER MCLEAN
6185	ONS/ONCC CHEMO IMMUNOTHERAPY (Summ trans)	112125	324.00	999051012	GONINA SLEFOSH
6185	ONS CANCER BASICS (Summ trans)	120425	227.00	999051014	YUMI STEARS
6185	ONS/ONCC CHEMO- IMMNOTHERAPY (Summ trans)	120425	325.00	999051014	YUMI STEARS
8740	MSN	011426 EDU	4,561.22	84495	PLOUNT NATHAN
8740	CPCS RECERTIFICATION (Summ trans)	010626	200.00	999051020	TAMRA S PECORARO
8740	NRP	011226 EDU	200.00	84491	ADDISON MICHELLE
8740	TUITION REIMBURSEMENT (Summ trans)	121625	2,340.00	999051015	JENNIFER MILLER
8740	RESP THER DISEASE (Summ trans)	121925	200.00	999051017	MENA KHOJA
8740	PHARMACOLOGY 2025 (Summ trans)	121925	200.00	999051018	AUDREY OCHINANG
8740	ADV SPECIALTY CERT- CHWS (Summ trans)	012626	200.00	999051022	ALDRICH DE LOS SANTO
8740	CRITICAL CARE PHARM	121925 EDU	200.00	84382	AVANESOV ARTHUR
8740	RN TO BSN (Summ trans)	012626	2,500.00	999051021	KRISTOFER CASTRO

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of \$100.00.

**Detailed backup is available from the Finance department upon request.