TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Hospital Organizational Chart and Chain of Command

I. Organizational Chart

A. In an effort to clarify leadership responsibility, the attached Tulare Regional Medical Center (TRMC) organizational chart is established.

B. Should an employee have questions or doubt as to reporting responsibilities or working relationships with others, the employee should feel free to contact any department leader.

II. Chain of Command

A. The Tulare Regional Medical Center Board of Directors has ultimate and final authority and responsibility for all matters relating to Tulare Regional Medical Center.

B. The Board has delegated the Chief Executive Officer full authority and responsibility for all Hospital operations.

C. In the absence of the CEO, the following "chain of command" is hereby established to expedite timely decision making:

1. Chief Financial Officer/Chief Operations Officer (COO/CFO)

2. Chief ~~Clinical~~ Nursing Officer (C~~C~~NO)

3. ~~VP~~Director of Quality

4. House Supervisor (Reports to C~~C~~NO)

5. Directors so designated shall have full authority to represent Tulare Local Health Care District until the CEO is contacted and assumes responsibility. The Chief of the Medical Staff and/or the appropriate Chief of Service shall be consulted as necessary for resolution of issues relating to patient care.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

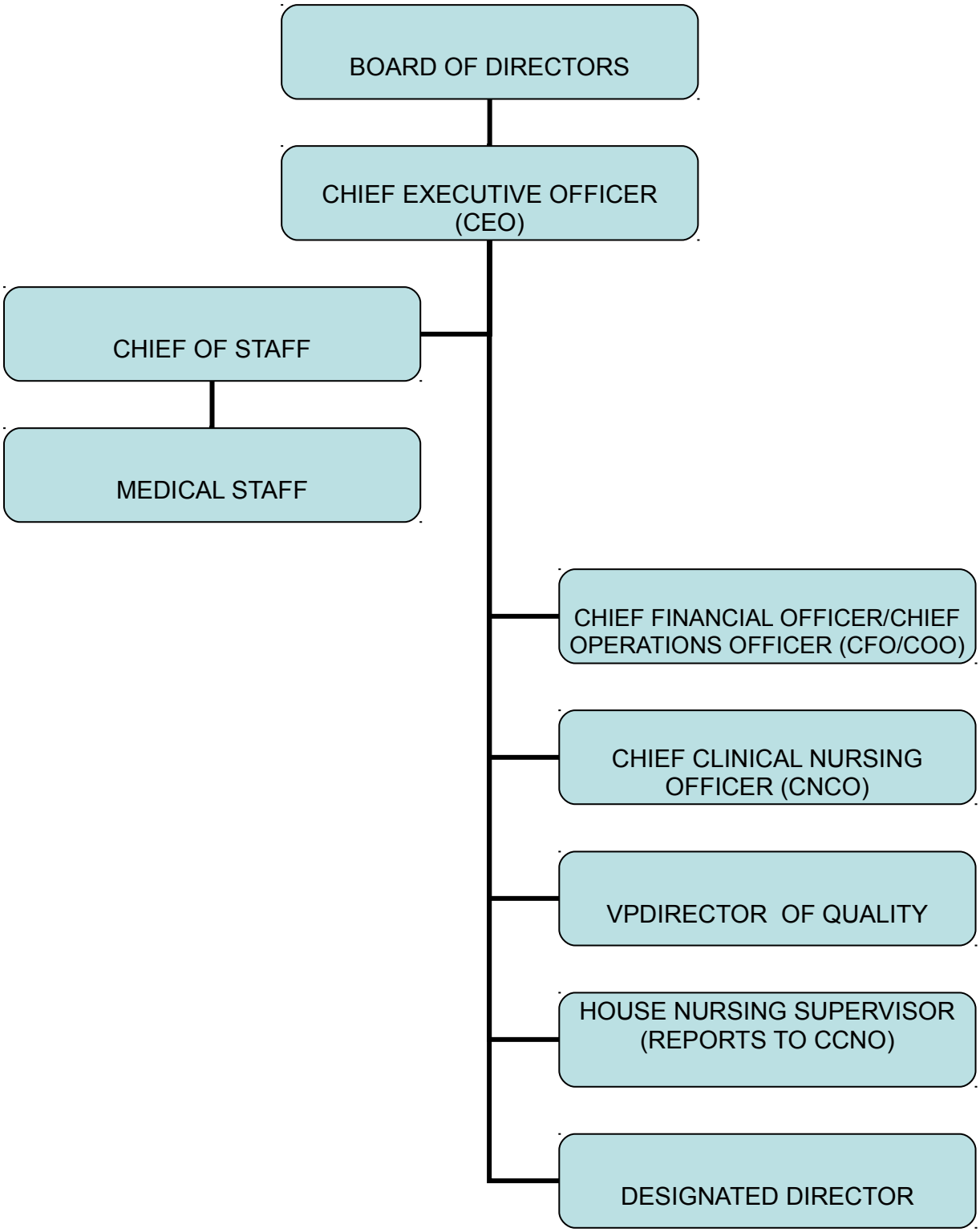
This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~01/27/11~~ (10) Administration
General:
Hospital Organizational Chart and Chain Of Command
10-1001

APPROVED:

Board Of Directors: ~~01/26/11~~

CHAIN OF COMMAND



Descriptive Name:	Hospital Organizational Chart and Chain of Command
Descriptive Type:	Revised
Document Number:	10-1001
Attachments:	Chain of Command Flow Chart
Author:	~~Shawn Bolouki, CEO~~ Angie Graziano, CNO
Typist:	~~Julie Gresham~~ Maritza Sevillano
Creation Date:	09/30/10
Prev. Dist. Date:	8/23/07

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/26/11~~	

Effective Date:	~~01/27/11~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments, Medical Staff, and Board of Directors

FROM: Administration

SUBJECT: Organization Mission, Vision, and Values Statement

The **Mission** of Tulare Regional Medical Center is: To provide safe, efficient, technologically-advanced healthcare with respect for the diversity of our region.

The **Vision** is: To be the leader and preferred healthcare organization in the region.

The **Values** are:

Quality: To provide high quality care, based on the best practices and in collaboration with medical staff that exceeds patient expectations.

Customer Service: To provide compassionate, courteous, respectful and dignified care, maintaining confidentiality and sensitivity to every individual.

Compliance/Ethics: To comply with regulatory requirements based on the highest ethical standards.

Finance/Efficiency: To conduct operations according to best practices in order to achieve financial goals.

People: To be the organization of choice for high quality, culturally diverse employees and medical staff.

Growth: To expand access and availability of healthcare while growing services based on regional need.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: ~~02/25/10~~	(10)	Administration General: Organization Mission, Vision, and Values Statement 10-1002
APPROVED:		
Board Of Directors: ~~02/24/10~~		

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Organization Mission, Vision, and Values Statement
Descriptive Type:	Revised
Document Number:	10-1002
Attachments:	None
Author:	~~Shawn Bolouki, CEO~~
Typist:	~~Julie Gresham~~Carol Bradford
Creation Date:	02/13/10
Revision Date:	01/16/18
Previous Dist. Date:	12/02/04

Committee Review:	Approval Date:	Comments:
Board of Directors	~~02/24/10~~	

Effective Date:	~~02/25/10~~
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Approved by Senior Leadership 02/17/10

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Board of Directors, Employees, Medical Staff, Contractors and Vendors

FROM: Administration

SUBJECT: Standards of Ethical Conduct and Code of Conduct

PURPOSE: To define guidelines for compliance and ethical behavior by all personnel of the DISTRICT in carrying out their daily activities with respect and honor.

INTRODUCTION:

The DISTRICT has adopted a Compliance Program to ensure that the District operates in full compliance with all applicable laws. An important component of the program is a Code of Conduct (referred to as the "Code"), which sets out basic principles which all of the District and the District's subsidiaries, owners, directors, officers and employees (referred to as "personnel") and other persons acting on the DISTRICT's behalf must follow. This Code applies to all business operations. All personnel and other persons acting on the DISTRICT's behalf shall act in compliance with the requirements of applicable law and this Code and in a sound ethical manner when conducting business and operations.

It is the policy of the DISTRICT that:

- all owners, officers, directors, employees, contractors, subcontractors, agents, active medical staff and other persons who provide patient care items or services or who perform billing or coding functions on behalf of the District, **excluding** vendors whose sole connection with Tulare is selling or otherwise providing medical supplies or equipment to Tulare and who do not bill the Federal health care programs for such medical supplies or equipment are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring, and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of non-compliance without fear of retaliation; and
- Mechanisms exist to investigate, discipline and correct non-compliance.

If you have any questions about the Code or its applicability to a particular situation, please contact the Chief Compliance Officer of the District at 559-685-3816.

The DISTRICT's Compliance Program and this Code are not intended to and shall not be deemed or construed to provide any rights, contractual or otherwise, to any personnel or to any third parties.

STANDARDS OF CONDUCT:

1. One of the DISTRICT's strongest assets is a reputation for integrity and honesty. A fundamental principle on which the DISTRICT will operate its business is full compliance with all applicable laws. The DISTRICT will also conduct its business in conformance with its core values and sound ethical standards. Achieving business results by illegal acts or unethical conduct is not acceptable.

2. Each supervisor, manager and director is responsible for ensuring that the personnel within their supervision are acting ethically and in compliance with applicable law and the Code. All personnel are responsible for acquiring sufficient knowledge to recognize potential compliance issues applicable to their duties and for appropriately seeking advice regarding such issues.

3. The Code of Conduct is distributed to all applicable owners, officers, directors, employees, contractors, subcontractors, agents, active medical staff and other person acting on the DISTRICT's behalf and sets forth general standards applicable to all business and operations. Each person shall certify in writing, that he or she has received, read, understood and shall abide by the District's Code of Conduct The Code of Conduct will be reviewed annually and distributed to all applicable persons within 30 days of any revisions.

   In addition, there are a number of more detailed and specific policies contained within the Compliance Manual. The DISTRICT will communicate those specific policies to personnel and other person acting on the DISTRICT's behalf who are particularly affected by and who must comply with them in the course of the DISTRICT's business. A current set of such policies is available on the DISTRICT's Intranet site, Administration and Switchboard. If you have questions regarding any of compliance policies, please contact the Chief Compliance Officer at 559-685-3816.

4. Personnel and other persons acting on the DISTRICT's behalf shall not offer or give nor shall they accept any bribe, payment, gift or thing of value to or from any person or entity with whom the DISTRICT has or is seeking any business or regulatory relationship except for gifts of a nominal value (not more than $10.00 per item, provided that the total value of gifts from the same source is not more than $50.00 in a calendar year) which are legal and given in the ordinary course of business. Personnel and other persons acting on the DISTRICT's behalf must promptly report the offering or receipt of gifts above a nominal value to their supervisor. California law treats gifts as

income and gifts in excess of the nominal value may be required to be reported on the individual's statement of economic interests.

5. Personnel and other persons acting on the DISTRICT's behalf shall not directly or indirectly authorize, pay, promise, deliver, or solicit any payment, gratuity, or favor for the purpose of influencing any political official or government employee in the discharge of that person's responsibilities. Personnel shall not entertain government personnel in connection with any DISTRICT business.

6. Personnel and other persons acting on the DISTRICT's behalf shall be completely honest in all dealings with government agencies and representatives. No misrepresentations shall be made, and no false bills or requests for payment or other documents shall be submitted to government agencies or representatives. Personnel and other person acting on the DISTRICT's behalf certifying the correctness of records submitted to government agencies, including bills or requests for payment, shall have knowledge that the information is accurate and complete before giving such certification.

7. All political activities relating to the DISTRICT shall be conducted in full compliance with all applicable laws. No DISTRICT funds or property shall be used for any political contribution or purpose unless first approved by the CEO and the DISTRICT's legal counsel. Personnel and other person acting on the DISTRICT's behalf may make direct contributions of their own money to political candidates and activities of their choice, but these contributions will not be reimbursed by the DISTRICT.

8. Other than compensation from the DISTRICT, and as consistent with the conflict of interest policies, personnel and other person acting on the DISTRICT's behalf shall not have a financial or other personal interest in any transaction between the DISTRICT or any of its business units and any vendor, supplier, or provider.

9. Personnel and other person acting on the DISTRICT's behalf shall not engage in any financial, business, or other activity which competes with the DISTRICT's business which may interfere or appear to interfere with the performance of their duties or that involve the use of DISTRICT property, facilities, or resources, except to the extent consistent with the conflict of interest policies.

10. All of the DISTRICT's business transactions shall be carried out in accordance with management's general or specific directives. All of the books and records shall be kept in accordance with generally accepted accounting standards or other applicable standards. All transactions,

payment, receipts, accounts, and assets shall be completely and accurately recorded on the DISTRICT's books and records on a consistent basis. No payment shall be approved or made with the intention or understanding that it will be used for any purpose other than that described in the supporting documentation for the payment. All information recorded and submitted to other persons must not be used to mislead those who receive the information or to conceal anything that is improper.

11. Books and records shall be created, maintained, retained, or destroyed in accordance with the DISTRICT's records management and retention policy and/or practice.

12. Personnel or other persons acting on the DISTRICT's behalf shall comply with applicable antitrust laws. There shall be no discussions or agreements with competitors regarding price or other terms for product sales, prices paid to suppliers or providers, dividing up customers or geographic markets, or joint action to boycott or coerce certain customers, suppliers, or providers of the DISTRICT.

13. The DISTRICT and its personnel and other person acting on the DISTRICT's behalf shall not engage in unfair competition or deceptive trade practices, including misrepresentation of the DISTRICT's products or operations. Personnel shall not make false or disparaging statements about competitors or their products or attempt to coerce suppliers or providers into purchasing products or services.

14. All personnel and other person acting on the DISTRICT's behalf shall maintain the confidentiality of the DISTRICT's business information and of information relating to the DISTRICT's vendors, suppliers, providers. Personnel and other person acting on the DISTRICT's behalf shall not use any such confidential or proprietary information except as is appropriate for DISTRICT business. Personnel and other person acting on the DISTRICT's behalf shall also not seek to improperly obtain or to misuse confidential information of the DISTRICT's competitors.

15. The DISTRICT is committed to full compliance with all laws and regulations protecting patient privacy and the confidentiality of patient information, medical and otherwise. Confidential patient information should be discussed with or disclosed to personnel on a limited, "minimum necessary" basis. Protected health Information should only be disclosed to others in response to a permitted or authorized request. At no time should confidential patient information be discussed with or disclosed to non-DISTRICT personnel, including the family or business or social acquaintances of DISTRICT personnel, vendors, suppliers, providers or patients.

16. All personnel and other person acting on the DISTRICT's behalf shall follow safe work practices and comply with all applicable safety standards and health regulations.

17. All personnel and other person acting on the DISTRICT's behalf are responsible for ensuring that the work environment is free of discrimination or harassment due to age, race, gender, color, religion, national origin, ancestry, disability (physical or mental), medical condition, marital status, sex, sexual orientation, or covered veteran status. Any form of sexual harassment, including the creation of a hostile working environment, is completely prohibited.

REPORTING OF SUSPECTED VIOLATIONS:

1. Illegal acts or improper conduct may subject the DISTRICT to severe civil and criminal penalties, including large fines and being barred from certain types of business. It is, therefore, very important that any illegal activity or violations of the Code be promptly brought to the DISTRICT's attention. In many cases, if the DISTRICT discovers and reports illegal acts to the appropriate governmental authorities, the DISTRICT may be subject to lesser penalties.

2. Any director, officer, employee or other persons acting on the DISTRICT's behalf who believes or becomes aware of any violation of this Code or any illegal activity by a director, officer, employee, health care provider or other person acting on the DISTRICT's behalf, shall promptly report the suspected violation in person, by phone, or in writing, to one of the following persons:

    a. Chief Compliance Officer either in person or by phone at 559-685-3816;
    b. Toll-free Compliance Hotline 1-888-633-9391 or local number at 559-684-4502;
    c. Compliance Complaint in writing delivered to the Compliance Complaint drop box located in the hospital cafeteria;
    d. The appropriate supervisor, manager or director of the department; or
    e. Any senior management staff member.

3. It is a violation of this code for any director, officer, employee, health care provider or other person acting on the DISTRICT's behalf not to report a violation of this Code or any illegal activity. If you have a question about whether particular acts or conduct may be illegal or violate the Code, you should contact one of the persons listed above. It is a violation of the Code for any person to whom a potential or suspected illegal act or violation of this Code is reported to not ensure that the illegal act or violation of the Code comes to the attention of those responsible for investigating such reports.

If the illegal acts or conduct in violation of the Code involves a person to whom such illegal acts or violations might otherwise be reported, the illegal acts or violation should be reported to another person identified in paragraph 2 above, to whom reporting is appropriate.

4. It is the DISTRICT's policy to promptly and thoroughly investigate reports of illegal activity or violations of this Code. All directors, officers, employees, health care providers or other persons acting on the DISTRICT's behalf must cooperate with these investigations. It is a violation of this code to prevent, hinder, or delay discovery and full investigation of illegal acts or violation of this Code.

5. Any director, officer, employee, health care provider or other person acting on the DISTRICT's behalf may report illegal acts or a violation of this Code anonymously by calling the DISTRICT's toll-free Compliance Hotline at 1-888-633-9391 or local number at 559-685-4502. To the extent permitted by law, the DISTRICT will take reasonable precautions to maintain the confidentiality of those individuals who report illegal activity or violations of this Code and of those individuals involved in the alleged improper activity, whether or not it turns out that improper acts occurred.

6. All directors, officers, employees, health care providers or other persons acting on the DISTRICT's behalf shall cooperate in any investigation of suspected illegal activity or violations of this Code. During the investigation, personnel and other person acting on the DISTRICT's behalf shall keep not only the fact an investigation is occurring, but also the nature and content of his or her participation in the investigation confidential and shall only release or disseminate such information to those who have a clear need to know and are involved in the investigation. Failure to abide by this confidentiality obligation is a violation of this Code.

7. No retaliation, reprisals or disciplinary action will be taken or permitted against any director, officer, employee, health care provider or other person acting on the DISTRICT's behalf for good faith reporting of, or cooperating in the investigation of, suspected illegal acts or violations of this Code. However, personnel are subject to disciplinary action if after an investigation, the DISTRICT reasonably concludes that the reporting personnel knowingly fabricated or knowingly distorted, exaggerated, or minimized the facts to either cause harm to someone else or to protect or benefit themselves. It is a violation of this Code for directors, officers, employees, health care providers or other persons acting on the DISTRICT's behalf to punish, retaliate or conduct reprisals against any person who have made a good faith report of, or cooperated in the investigation of, suspected illegal acts or violations of this Code.

8. Personnel who violate the Code or commit illegal acts are subject to discipline up to and including termination of their employment with the DISTRICT. Personnel who report their own illegal acts or improper conduct, however, will have such self-reporting taken into account in determining the appropriate disciplinary action.

GOVERNMENT INTERVIEWS OR INVESTIGATION:

1. The DISTRICT and its directors, officers, employees, health care providers or other persons acting on the DISTRICT's behalf shall cooperate fully and promptly with appropriate government investigations into possible administrative, civil and criminal violations of the law. It is important, however, that in this process the DISTRICT is able to protect the legal rights of the DISTRICT and its personnel. To accomplish these objectives, any governmental inquiries or requests for information, documents, or interviews should be promptly referred to the Chief Compliance Officer or the general legal counsel's office for the DISTRICT.

2. All directors, officers, employees, health care providers or other persons acting on the DISTRICT's behalf who participate in government interviews or investigations shall provide information that is truthful, complete and unambiguous.

Questions concerning any aspect of this policy/guideline should be referred to the Chief Compliance Officer at 559-685-3816.

This policy/guideline replaces and supersedes all previous policies/guidelines of this number and is effective immediately.

Descriptive Name:	Standards of Ethical Conduct and Code of Conduct
Descriptive Type:	Revised
Document Number:	10-1002.1
Attachments:	None
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, RN Chief Compliance Officer
Typist:	Julie Gresham
Creation Date:	09/23/09
Revision Date:	~~04/01/14~~4/24/18
Prev. Dist. Date:	04/25/13

Committee Review and Approval:	Approval Date:	Comments:
Compliance Committee	n/a~~04/10/14~~	Date change only
Board of Directors	06/25/14	

Effective Date:	06/26/14
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Board of Directors, Employees, Contractors and Medical Staff

FROM: Administration

SUBJECT: Compliance Screening Procedure for Employees, Contractors and Medical Staff

It is the policy of the DISTRICT to make reasonable inquiry into the background of prospective employees and vendors whose job function or activities may materially impact the Medicare/Medicaid claim development and submission process, the organization's relationship with physicians, or referral patterns between providers.

1. **Employees.** All employees who provide services which may be reimbursed, directly or indirectly, by a Federal health care program shall be screened to determine whether they have been (a) convicted of a criminal offense related to healthcare; or (b) listed by a Federal agency as debarred, excluded or otherwise ineligible for federal program participation.

   - The screening requirement applies to all employees where the services they provide may be reimbursed, directly or indirectly, by a Federal health care program.

2. **Vendors and Contractors.** All vendors and contractors providing services which may be reimbursed, directly or indirectly, by a Federal health care program, shall be screened to determine whether such vendor or contractor has been (a) convicted of a criminal offense related to healthcare (unless such person or entity has implemented a compliance program as part of an agreement with the Federal government); or (b) listed by a federal agency as debarred, excluded or otherwise ineligible for Federal program participation.

3. **Inquiry.** In attempting to ascertain whether an individual or entity is ineligible, the DISTRICT shall review the following sources:

   - DHHS/OIG Excluded Individuals/Entities Search. The report may be accessed on the World Wide Web at http://exclusions.oig.hhs.gov/. Questions may be directed to: Office of the Inspector General, Office of Enforcement and Compliance, 7500 Security Boulevard, Room N2-01-26, Baltimore, Maryland, 21244, (410) 786-9603, or e-mail at sanction@oig.hhs.gov.

System for Award Management (SAM) is **a Federal Government owned and operated** free web site that consolidates the capabilities in CCR/FedReg, ORCA, and EPLS. The report may be accessed on the World Wide Web athttps://sam.gov.

4. All employees and vendors must sign or incorporate into their contracts commitment to compliance with HIPAA/HITECH confidentiality requirements.

Questions concerning any aspect of this policy/guideline should be referred to Chief Compliance Officer ~~at 559-685-3816~~.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Compliance Screening Procedure for Employees, Contractors and Medical Staff
Descriptive Type:	Revised
Document Number:	10-1002.3
Attachments:	None
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, Chief Compliance Officer
Typist:	~~Julie Gresham~~ Ena Menezes/ Andrea Carrasco
Creation Date:	08/12/08
Revisions Date:	~~04/01/14~~ 02/01/18
Prev. Dist. Date:	04/25/13

Committee Review and Approval:	Approval Date:	Comments:
Compliance Committee	~~04/10/14~~	
Board of Directors	~~06/25/14~~	

Effective Date:	~~06/26/14~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Compliance Enforcement, Investigation and Discipline

The purpose of this policy is to set forth the procedures that will be used by the DISTRICT to respond to reports by employees or others that a business unit or individuals employed by or contracting with a business unit are engaging in activity which may be contrary to applicable Medicare and/or Medicaid laws or regulations, including but not limited to reports that such persons or business units may be submitting claims in a manner which does not meet the Medicare and/or Medicaid program requirements.

I. INVESTIGATION

A. Purpose of Investigation

The purpose of the investigation shall be to identify those situations in which the laws, rules and standards of the Medicare and/or Medicaid programs may not have been followed; to identify individuals who may have knowingly or inadvertently caused claims to be submitted or processed in a manner which violated Medicare or Medicaid laws, rules, or standards; to facilitate the correction of any practices not in compliance with the Medicare and/or Medicaid laws, rules and standards; to implement those procedures necessary to ensure future compliance; to protect the DISTRICT in the event of civil or criminal enforcement actions, and to preserve and protect the DISTRICT's assets.

B. Control of Investigations

All reports received, whether by an employee of the DISTRICT's or others acting on the behalf of the DISTRICT or directly through the law or internal audit departments shall be forwarded to the Chief Compliance Officer either in person, by phone or in writing (see attached reporting form). Compliance matters will be routinely reported to the CEO and Legal Counsel by the Chief Compliance Officer. Depending upon the nature of the incident, the CFO and/or the appropriate Senior Leader may also be notified in undertaking the investigation, the Chief Compliance Officer may request the assistance of department managers or other appropriate employees and may solicit the support of an internal audit, external counsel and auditors, as well as internal

and external resources with knowledge of the applicable laws and regulations and required policies, procedures or standards that relate to the specific problem in question.

Any employee or other persons assisting the Chief Compliance Officer with an investigation of issues or concerns shall work with others with the knowledge and background to assist them and shall be required to submit relevant evidence, notes, findings and conclusions to the Chief Compliance Officer. The CEO and Legal Counsel shall be kept apprised of investigative events by the Chief Compliance Officer.

C. Investigative Process

Upon receipt of a complaint or other information (including audit results) which suggests the existence of a violation of compliance policies or applicable laws or regulations, an investigation shall be commenced by the Chief Compliance Officer. Steps to be followed in undertaking the investigation shall include, at a minimum:

1. The investigation shall be commenced as soon as reasonably possible but in no event more than five business (5) days following the receipt of the complaint or report. The investigation shall include, as applicable, but need not be limited to:

    a. An interview of the complainant and other persons who may have knowledge of the alleged problem or process and a review of the applicable laws and regulations which might be relevant to or provide guidance with respect to the appropriateness or inappropriateness of the activity in question, to determine whether or not a problem actually exists.

    If the review results ends in conclusions or findings that the conduct in question is permitted under applicable laws, regulations or policy, or that the complained of act did not occur as alleged or that it does not otherwise appear to be a problem, the investigation shall be closed.

    If the initial investigation concludes that there is improper billing occurring, that practices are occurring which are contrary to applicable law, that inaccurate claims are being submitted, or that additional evidence is necessary, the investigation shall proceed to the next step.

b. The identification and review of representative bills or claims submitted to the Medicare and/or Medicaid programs to determine the nature, scope, frequency of the problem, duration, and the potential financial magnitude of the problem.

c. Interviews of the person or persons in the departments and organization who appeared to play a role in the process in which the problem exists. The purpose of the interview will be to determine the facts related to the activities or conduct in question, and may include, but shall not be limited to:

i. Individual understanding of the Medicare and Medicaid laws, rules and regulations;
ii. the identification of persons with supervisory or managerial responsibility in the process;
iii. the adequacy of the training of the individuals performing the functions within the process;
iv. the extent to which any person knowingly or with reckless disregard or intentional indifference acted contrary to the Medicare and/or Medicaid laws, rules or regulations;
v. the nature and extent of potential civil or criminal liability of individuals or the DISTRICT; and
vi. preparation of a summary report which:
1) defines the nature of the problem,
2) summarizes the investigation process,
3) identifies any person whom the investigator believes to have either acted deliberately or with reckless disregard or intentional indifference toward the Medicare/Medicaid laws, rules and policies,
4) if possible, estimates the nature and extent of the resulting overpayment by the government, if any.

II. ORGANIZATIONAL RESPONSE

A. Possible Criminal Activity

In the event the DISTRICT uncovers what appears to be criminal activity on the part of any employee or others acting on the behalf of the DISTRICT or business unit, it shall undertake the following steps:

1. Immediately stop all billing related to the problem in the unit(s) where the problem exists until such time as the offending practices are corrected.

2. After appropriate investigation initiate appropriate disciplinary action against the person or persons whose conduct appears to have been intentional, willfully indifferent or with reckless disregard for the Medicare and Medicaid laws. Appropriate disciplinary action shall include, at a minimum, the removal of the person from any position with oversight for or impact upon the claims submission or billing process and may include, in addition, suspension, demotion, and discharge.

B. Other Non-Compliance

In the event the investigation reveals billing or other problems which do not appear to be the result of conduct which is intentional, willfully indifferent, or with reckless disregard for the Medicare and Medicaid laws, the DISTRICT shall nevertheless undertake the following steps.

1. Improper Payments. In the event the problem results in duplicate payments by Medicare or Medicaid, or payments for services not rendered or provided other than as claimed, it shall:

    a. Correct the defective practice or procedure as quickly as possible;
    b. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.
    c. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

2. No Improper Payment. In the event the problem has or does not result in an overpayment by the Medicare or Medicaid program, the DISTRICT shall:

    a. Correct the defective practice or procedure as quickly as possible.
    b. Initiate such disciplinary action, if any, as may be appropriate given the facts and circumstances. Appropriate disciplinary action may include, but is not limited to, reprimand, demotion, suspension and discharge.
    c. Promptly undertake a program of education at the appropriate business unit to prevent future similar problems.

III. CONCLUSION OF INVESTIGATION

At the conclusion of any investigation, a written report of the findings shall be prepared by the Chief Compliance Officer. (See attached Summary of Concern form). The CEO, Legal Counsel and Board of Directors will be informed of the outcome of the investigation. The reporting party, if identified and other individuals, as appropriate, shall be apprised of the completion of the investigation, and when appropriate, the results.

III. DISCIPLINE

Employees may be subject to discipline for failing to participate in organizational compliance efforts, including, but not limited to:

1. The failure of an employee to perform any obligation required of the employee relating to the compliance program or applicable laws or regulations;

2. The failure to report suspected violations of compliance program laws or applicable laws or regulations to an appropriate person; and

3. The failure on the part of a supervisory or managerial employee to implement and maintain policies and procedures reasonably necessary to ensure compliance with the terms of the program or applicable laws and regulations.

Discipline should follow the DISTRICT's existing employee discipline policies and procedures.

Questions concerning any aspect of this policy/guideline should be referred to the Chief Compliance Officer ~~at 559-685-3816~~.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

REPORT OF POTENTIAL NON-COMPLIANCE

Tulare Regional Medical Center

Please complete this form and forward it directly to the Chief Compliance Officer or compliance drop box for review.

Part I

Date and Time of Report: _____ / _____ am/pm

Name and Department of individual originating report (unless you wish to remain anonymous):

_____

Subject of Report: _____

Date(s) of Alleged Non-Compliance: _____

Department(s) Involved: _____

Witness name(s) and department(s) involved (unless witnesses wish to remain anonymous): _____

_____

_____

_____

Summary of Report: _____

_____

_____

_____

_____

_____

Part II (To be completed by the Chief Compliance Officer)

Date and time report received: _____

Report Received by: _____ Hotline _____ Chief Compliance Officer _____ Drop Box _____ Mail

Other: _____

NOTE: *The Chief Compliance Officer will maintain this report in a confidential manner. Forms may be deposited in the Compliance Drop box, or mailed to the attention of: Julie Gresham, RN Chief Compliance Officer at 869 Cherry Street, Tulare, CA. 93274. You may also contact the Chief Compliance Officer by calling the toll-free Compliance Hotline number 1-888-633-9391 or local number 559-684-4502. Any questions should be directed to the Chief Compliance Officer at 559-685-3816.*

If you chose to remain anonymous, the Chief Compliance Officer may not be able to notify you directly of the outcome of any investigations that are undertaken.

TO: FILE
FROM: Chief Compliance Officer
DATE:
SUBJECT:
Cc:

SUMMARY OF CONCERN/ISSUE/EVENT:

SCOPE OF ISSUE IDENTIFIED:

PLAN OF CORRECTIVE ACTION:

RESPONSIBLE INDIVIDUALS/TIME FRAMES FOR COMPLETION:

METHOD OF MONITORING FOR COMPLIANCE:

COMPLIANCE MONITORING
ISSUES/CONCERNS/PROBLEMS

REFERRED TO _____

Date Received	Reported To:	Nature of Complaint	Referral/Follow/Up

Descriptive Name:	Compliance Enforcement, Investigation and Discipline
Descriptive Type:	Revised
Document Number:	10-1002.4
Attachments:	Yes
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, Chief Compliance Officer
Typist:	~~Julie Gresham~~Ena Menezes/Andrea Carrasco
Creation Date:	09/23/09
Revision Date:	~~04/01/14~~ 02/01/18
Prev. Dist. Date:	04/25/13

Committee Review and Approval:	Approval Date:	Comments:
Compliance Committee	~~04/10/14~~	
Board of Directors	~~06/25/14~~	

Effective Date:	~~06/26/14~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Responsibility of Compliance, Fraud and Abuse

It is the policy of the DISTRICT to fully comply with all laws and regulations pertaining to the delivery of and billing for services which apply to the DISTRICT on account of its participation in Medicare, Medicaid and other government programs. Compliance in these areas is accomplished by accurately following the government's rules and regulations on Medicare and Medicaid billing system requirements and other guidelines.

I. INTRODUCTION

The DISTRICT has developed a fraud and abuse compliance program with a comprehensive statement of the responsibilities and obligations of all employees regarding submissions for reimbursement to Medicare, Medicaid, and other government payers for services rendered by the DISTRICT and any of its subsidiaries, divisions and contractors. In addition, this policy will apply to business arrangements with physicians, vendors, hospitals and other persons which may be impacted by federal or state laws relating to fraud and abuse.

II. EMPLOYEE PARTICIPATION AND REPORTING

It is the responsibility of every employee to abide by applicable laws and regulations and support the DISTRICT's compliance efforts.

All employees are required to report their good faith belief of any violation of the Compliance Program or applicable law. The DISTRICT, at the request of the employee, will provide such anonymity to the reporting employee(s) as is possible under the circumstances. This will depend on Administration's final approval, consistent with its obligations to investigate employee concerns and take necessary corrective action. There shall be no retaliation in the terms and conditions of employment as a result of such reporting.

Employees will report their good faith belief or violations of the Compliance Program or applicable laws either orally or in writing to:

- Chief Compliance Officer either in person or by phone ~~at 559-685-3816;~~

- Toll-free Compliance Hotline at 1-888-633-9391 ~~or local number at 559-684-4502;~~
- Compliance Complaint in writing delivered to any Compliance Complaint drop box located in the hospital's cafeteria;
- The appropriate supervisor, manager or director of the department;
- Any senior management staff member.

Employees may also bring a civil action for a violation of state or federal laws regarding billing. The hospital may not retaliate against an employee who files a civil action for state violations, or who reports such violations to the state authorities.

IV. RESPONSIBLE OFFICER

The DISTRICT has designated the Chief Compliance Officer as the individual responsible for overall implementation and operation of the compliance program. The Chief Compliance Officer shall be responsible to ensure, delegate, and assign that:

- Compliance policies are reviewed and updated as necessary;
- Employee and vendor screening mechanisms are in place and are operating properly;
- Employees are receiving adequate education and training regarding Compliance Program requirements and that such education and training is documented;
- Audit procedures are implemented in accordance with the DISTRICT's audit policies and procedures;
- Employee complaints and other concerns regarding compliance are promptly investigated; and
- Adequate steps are taken to correct any identified problems and prevent the reoccurrence of such problems.

V. REPORT TO THE BOARD

The Chief Compliance Officer shall report in writing quarterly to the District Compliance Committee and no less than annually to the Board of Directors on the status of compliance within the organization. This report shall include the results of any recommendations from the audit work plans conducted during the prior year, and any other information requested by the Committee or the Board.

Questions concerning any aspect of this policy/guideline should be referred to the Chief Compliance Officer ~~at 559-685-3816~~.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Responsibility of Compliance, Fraud and Abuse

Descriptive Type: Revised

Document Number: 10-1002.5

Attachments: None

Author: Rachele Berglund Bailey, General Legal Counsel
Julie Gresham, Chief Compliance Officer

Typist: ~~Julie Gresham~~Ena Menezes/Andrea Carrasco

Creation Date: 09/23/09

Revision Date: ~~04/01/14~~ 02/01/18

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Committee Review and Approval:	Approval Date:	Comments:
Compliance Committee	~~04/10/14~~	
Board of Directors	~~06/25/14~~	

Effective Date: ~~06/26/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments and Employees

FROM: Administration

SUBJECT: Claim Development and Submission Compliance Auditing

In furtherance of its obligations as a participant in Medicare and other government funded healthcare payment programs, the DISTRICT has adopted this audit policy to assist in its efforts to monitor the accuracy of claims. This policy is adopted to ensure that representative claims from all of the DISTRICT's individual and institutional providers are periodically reviewed in a manner which will enable the organization to promptly identify deficiencies in the claim development and submission process which may result in inaccurate claims.

I. AUDITING PROCESS

A. The DISTRICT will conduct audits in accordance with the schedule set forth below. The audits will be executed in accordance with the policies and procedures contained in the applicable auditing tool or protocol utilized by the organization. The DISTRICT will devote such resources as are reasonably necessary to ensure that the audits are
   (1) adequately staffed;
   (2) by persons with appropriate knowledge and experience to conduct the audits; and
   (3) utilizing audit tools and protocol which are periodically updated to reflect changes in applicable laws and regulations.

II. AUDIT PLAN

A. **New employee audits.** It is the policy of the DISTRICT and the responsibility of each department director to ensure that employees who are new to a position which has a direct impact on the claim development and submission process are provided adequate and appropriate training. One mechanism for ensuring the accuracy of claims is to ensure that each new employee adequately understands the essential elements of his/her job functions. In furtherance of this objective, it is the policy of the DISTRICT to review the work of new employees in the manner set forth below:

1. **Billers and Coders.** Each employee whose principle function includes the billing or coding of claims to be submitted to the Medicare or Medicaid program shall have all or a representative sample, of such employee's claims related work reviewed by the employee's manager or an experienced co-worker or an outside auditor, for a period of not less than 30 days following their commencement date, or such later date as the manager is satisfied that the accuracy of employee's claims justify cessation of the reviews.

2. **Admitting/Registration.** The work of every new employee to admitting/registration shall be reviewed by the employee's manager or an experienced co-worker or an outside auditor for a period of not less than 30 days following their commencement date or until such time as the employee's manager is satisfied that the accuracy of the employee's work is adequate to justify cessation of the review.

3. **Patient Care Providers.** New patient care providers shall be provided written guidelines with respect to documentation services that will be rendered by such providers as assigned by department director/manager. The department director/manager shall review periodically the provider's documentation to ensure that the provider is accurately and completely documenting the services rendered by the provider.

   For the purpose of this policy, the term provider includes physicians, nurses, allied health professionals and other persons who may document the delivery of services in the provider's records (including medical records).

B. **Periodic Audits.** The DISTRICT will conduct periodic audits of submitted claims either internally or by a contracted service. Appropriate action will be taken for any inaccuracies noted.

C. **Complaint Audits.** Upon receipt of a credible allegation or complaint alleging improper or inaccurate billing practices, the DISTRICT shall undertake a review of the matter. The review process will meet the requirements set forth in the DISTRICT's Policy No. 10-1002.4, Compliance Enforcement, Investigation and Discipline.

II. Compliance with applicable billing, coding, and other aspects of claims management procedures will be accomplished through appropriate training of staff and routine audits for accuracy and compliance. Employees who are non-compliant and whose work is not remedied through reasonable further training and auditing will be subject to disciplinary action, up to and including termination.

Questions concerning any aspect of this policy/guideline should be referred to the Chief Compliance Officer ~~at 559-685-3816~~.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Claim Development and Submission Compliance Auditing
Descriptive Type:	Revised
Document Number:	10-1002.7
Attachments:	None
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, Chief Compliance Officer
Typist:	~~Julie Gresham~~Ena Menezes/Andrea Carrasco
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Committee Review and Approval:	Approval Date:	Comments:
Compliance Committee	~~04/10/14~~	
Board of Directors	~~06/25/14~~	

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Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Principles of Compliance

PURPOSE: To define the resources and guidelines used to support ethical practices and behaviors for compliance with the Standards of Ethical Conduct.

The DISTRICT has an ethical responsibility to the patients and community it serves. The organization relies on its Mission, Vision, and Values statement to guide overall practices in ethical behavior as it interacts with patients, families, physicians, staff, and community. Ethical behavior is an expectation in all aspects of healthcare delivery such as in admissions, transfers, discharges, nursing care, billing, accounting, and marketing activities.

I. Important components of ethical behavior are based on codes and standards acquired from many resources and guidelines utilized by the organization including but not limited to the following:

A. The Mission, Vision, and Values statement
B. The Performance Improvement Plan
C. The Corporate Compliance Plan Policies
D. Code of Ethics and Standards (American Society of Business Offices)
E. Debt Disputes, Business Services and Admission Policy and Procedures
F. California Consent Manual
G. COBRA/OBRA Regulations
H. Conflict of Interest Statements
I. Joint Commission Accreditation, Det Norske Veritas Accreditation (DNV) and/or Other Accreditation Agency
J. Applicable Title 22 Standards related to Services Provided
K. CMS Regulations related to Services Provided
L. Medicare/Medicaid Billing Guidelines
M. Patient Safety Plan
N. HIPAA/HITECH
O. Mandatory Reporting Obligations Policy

II. Code of Conduct Principles: The DISTRICT will strive to ensure all activities by or on behalf of the organization are in compliance with applicable laws.

The following principles are intended to provide guidance to officers, employees and other persons acting on the DISTRICT's behalf to assist them in their obligation to comply with applicable laws. These principles are neither exclusive nor complete. Employees are required to comply with all applicable laws, whether or not specifically addressed in these policies. If questions regarding the existence of, interpretation or application of any law arise, they should be directed to Chief Compliance Officer ~~at 559-685-3816~~. Employees, or others, who act on behalf of the organization who do not comply with these principles, may be subject to discipline up to and including termination of employment.

A. Legal Compliance Principles

1. Antitrust: All employees and other persons acting on the DISTRICT's behalf must comply with applicable antitrust and similar laws, which regulate competition. Examples of conduct prohibited by the laws include: (1) agreement to fix prices, bid rigging, collusion (including price sharing with competitors); (2) boycotts, certain elusive dealing and price discrimination agreements; and (3) unfair trade practices including bribery, misappropriation of trade secrets, deception, intimidation and similar unfair practices. Employees and other persons acting on the DISTRICT's behalf who become aware should contact:

   a. Chief Compliance Officer either in person ~~or by phone at 559-685-3816;~~
   b. Toll-free Compliance Hotline at 1-888-633-9391 ~~or local number 559-684-4502;~~
   c. Compliance Complaint in writing delivered to the Compliance Complaint drop box located in the hospital's cafeteria;
   d. The appropriate supervisor, manager or director of the department;
   e. Any senior management leader.

2. Tax: As a public entity, the DISTRICT has a legal and ethical obligation to act in compliance with applicable laws, and to engage in activities to meet the needs of the community. As well, the DISTRICT must ensure that its resources are used in a manner which furthers the public good rather than the private or personal interests of any individual. Consequently, the DISTRICT and its employees and other persons acting on the DISTRICT's behalf will avoid compensation arrangements in excess of fair market value, will accurately report payments to appropriate taxing authorities, and will file all tax and information returns in a manner consistent with applicable laws. Employees and other persons acting on the DISTRICT's behalf may not use the DISTRICT's property or resources for a personal interest.

3. Fraud and Abuse: The DISTRICT expects its employees and other persons acting on the DISTRICT's behalf to refrain from conduct which may violate the fraud and abuse laws. These laws prohibit (1) direct, indirect or disguised payments in exchange for the referral of patients; (2) the submission of false, fraudulent or misleading claims to any government entity or third party payor, including claims for services not rendered, claims which characterize the service differently than the service actually rendered, or claims which do not otherwise comply with an applicable program or contractual requirements; and (3) making false representation to any person or entity in order to gain or retain participation in a program or to obtain payment for any service.

4. Mandatory Reporting of Abuse/Neglect: The DISTRICT's employees and independent contractors who have a mandatory reporting obligation under California law to report suspected abuse or neglect are expected to comply with that obligation and make such reports as required by law. Each hospital employee who is a health care practitioner or other mandated reporter will be provided written information regarding mandatory reporting obligations and must sign an Employee Acknowledgement Form confirming that the employee has read and understands his or her obligations under the mandatory reporting requirements and will comply with the provisions thereof. A yearly review of mandatory reporting requirements will be included in the Annual Update process as part of the DISTRICTs' Compliance Program. (For additional guidance, please refer to hospital policy regarding mandatory reporting requirements.)

5. Lobbying/Political Activity: The DISTRICT officers and employees are prohibited from engaging in political activities during working hours or on DISTRICT premises, except for any political activities which the DISTRICT is expressly required by law to permit. Questions about permissible political activities should be directed to Administration.

6. In addition:

    a. No individual may make agreement to contribute any money, property, or services of any officer or employee at the DISTRICT's expense to any political candidate, party, organization, committee, or individual in violation of any applicable law. Officers and employees may personally participate in and contribute to political organizations or campaigns, but they must do so as individuals, not as representatives of The DISTRICT and they must use their own funds.

b. Where its experience may be helpful and contribute to the understanding of issues, authorized representatives of the DISTRICT may publicly offer recommendations concerning legislation or regulations being considered. In addition, it may analyze and take public positions on issues that have a relationship to the operations of the organization.

c. The DISTRICT has many contacts and dealings with other governmental bodies and officials. All such contacts and transactions shall be conducted in an honest and ethical manner. Any attempt to influence the decision-making process of governmental bodies or officials by an improper offer of any benefit is absolutely prohibited. Any requests or demands by any governmental representative for any improper benefit should be immediately reported to or by the DISTRICT.

7. Environmental Standard: It is the policy of the DISTRICT to manage and operate its business in the manner which respects our environment and conserves natural resources. The DISTRICT's and other persons acting on the DISTRICT's behalf will strive to utilize resources appropriately and efficiently, to recycle where possible and otherwise dispose of all waste in accordance with applicable laws and regulations, and to work cooperatively with the appropriate authorities to remedy any environmental contamination for which the DISTRICT may be responsible.

8. Discrimination: The DISTRICT believes that the fair and equitable treatment of employees, patients and other persons is critical to fulfilling its vision and goals.

It is the policy of the DISTRICT to enroll subscribers and treat patients without regard to the race, color, religion, gender, national origin, age or disability of such person, or any other classification prohibited by law. It is also policy to employ, retain, promote, terminate and otherwise treat all employees, contract service providers and job applicants on the basis of merit, qualifications and competence, without regard to any qualified individual's sex (including gender identity), race, color, religion, national origin, ancestry, citizenship, pregnancy, age, marital status, sexual orientation, medical condition, or physical or mental disability, or any other classification prohibited by law.

No form of harassment or discrimination on the basis of individual's sex (including gender identity), race, color, religion, national origin, ancestry, citizenship, pregnancy, age, marital status, sexual orientation, medical condition, or physical or mental disability, or any other classification

prohibited by law will be permitted. Each allegation of harassment or discrimination will be promptly investigated in accordance with applicable human resource policies.

9. Business Ethics

To further the DISTRICT's commitment to the highest standards of business ethics and integrity, and other persons acting on the DISTRICT's behalf will accurately and honestly represent the DISTRICT and will not engage in any activity or scheme intended to defraud anyone of money, property or honest services.

The Standards set forth below are designed to provide guidance to insure that the DISTRICT's business activities reflect the high standards of business ethics and integrity.

a. Honest Communication: The DISTRICT requires candor and honesty from individuals in the performance of their responsibilities and in communication with our attorneys and auditors. No employee or other person acting on the DISTRICT's behalf shall make false or misleading statements to any patient, person or entity doing business with the DISTRICT about other patients, persons or entities doing business or competing with the DISTRICT, or about the products or services of the DISTRICT or its competitors.

b. Misappropriation of Proprietary Information: The DISTRICT employees and other persons acting on the DISTRICT's behalf shall not misappropriate confidential or proprietary information belonging to another person or entity nor utilize any publication, document, computer program, information or product in violation of a third party's interest in such product. All employees and other persons acting on the DISTRICT's behalf are responsible to insure they do not improperly copy for their own use documents or computer programs in violation of applicable copyright laws or licensing agreements. Employees and other persons acting on the DISTRICT's behalf shall not utilize confidential business information obtained from competitors, including customer's lists, price lists, contracts or other information in violation of a covenant not to compete, prior employment agreements, or in any other manner likely to provide an unfair competitive advantage to the DISTRICT.

c. Confidentiality: The DISTRICT employees and other persons acting on the DISTRICT's behalf shall maintain the confidentiality of patient and other confidential information in accordance with applicable legal

and ethical standards. The DISTRICT employees and other persons acting on the DISTRICT's behalf have an obligation to actively protect and safeguard confidential, sensitive and proprietary information in a manner designed to prevent the unauthorized disclosure of information. (See policy #13-9001and 15-2071).

d. Proprietary Information: Information, ideas and intellectual property assets of the DISTRICT are important to organizational success. Information pertaining to the DISTRICT's reimbursement information, and information relating to negotiations with employees, other persons acting on the DISTRICT's behalf or third parties should be protected and shared only with employees and other persons acting on the DISTRICT's behalf having a need to know such information in order to perform their job responsibilities. Employees and other persons acting on the DISTRICT's behalf should exercise care to insure that intellectual property rights, including patents, trademarks, copyrights and software is carefully maintained and managed to preserve and protect its value.

e. Personnel actions, decisions, and other personal information relating to employees shall be treated as confidential, except to the extent such information is required to be made available to the public pursuant to the Brown Act and/or the Public Records Act. Personnel files, payroll information, disciplinary matters and similar information shall be maintained in a manner designed to insure confidentiality in accordance with applicable laws. Employees and other persons acting on the DISTRICT's behalf will exercise due care to prevent the release or sharing of information beyond those persons who may need such information to fulfill their job function. Nothing in this section restricts employees from disclosing to any person the amount of his or her wages, or from disclosing information about the employee's working conditions.

III. Conflicts of Interest Principles

DISTRICT hereby incorporates by this reference Fair Political Practices Commission Regulation 18730.

For purposes of this part III, "designated positions" includes all Board of Director officers and members, DISTRICT officers, employees, general counsel and consultants** of DISTRICT whose position entails the making or participation in the making of governmental decisions that may foreseeably have a material effect on his or her financial interest.

For purposes of DISTRICT, the designated positions include:

Board of Director President
Board of Director Vice President
Board of Director Secretary
Board of Director Treasurer
Board of Director Member
Legal Counsel
Chief Executive Officer
Chief Operations Officer
Chief Financial Officer
Chief Compliance Officer
Chief Nursing Officer
Chief Information Officer
VP, Rural Health Clinics
VP, Quality
Patient Access Director
Case Management Director
Construction Management Director
Finance Director
Home Care Director
Human Resources Manager
Laboratory Director
Materials Management Director
Medical Imaging Director
Health Information Management Director
Medical Staff Director
Clinical Nursing Director's
Pharmacy Director
Plant Operations Director
Respiratory Care Director
Retail Pharmacy Director
Consultants**

**Consultants shall receive a copy of the DISTRICT Conflict of Interest Policy and be responsible for thoroughly reviewing the policy and shall thereafter, submit a signed acknowledgement that he/she has reviewed the policy, and attest that he/she has no disclosable conflicts. In the event the Consultant does have a disclosable conflict, he/she shall be responsible for promptly disclosing all such conflicts to the CEO or his/her designee.

Persons holding designated positions owe a duty of undivided and unqualified loyalty to the organization. Persons holding such positions may not use their

positions to profit personally or to assist others in profiting in any way at the expense of the organization.

All persons holding designated positions are expected to regulate their activities so as to avoid actual impropriety and/or the appearance of impropriety which might arise from the influence of those activities on business decisions of the DISTRICT, or from disclosure or private use of business affairs or plans of the DISTRICT.

Persons holding designated positions are required, by way of this policy, to disclose their interests as provided in Exhibit "A" to this policy.

A Statement of Economic Interests Form 700 (http://www.fppc.ca.gov/index.php?id=500) shall be completed by all persons holding designated positions each year.

A. Outside Financial Interests: While not all inclusive, the following will serve as a guide to the types of activities by a person holding a designated position, or household member of such person, which might cause conflicts of interest:

1. Ownership in or employment by any outside concern which does business with the DISTRICT. This does not apply to stock or other investments held in a publicly held corporation, *provided* the value of the stock or other investments does not exceed 5% of the corporation's stock. The DISTRICT may, following a review of the relevant facts, permit ownership interests which exceed these amounts if management concludes such ownership interests will not adversely impact the DISTRICT's business interest or the judgment of the covered person.

2. Conduct of any business not on behalf of the DISTRICT, with any vendor, supplier, contractor, or agency, or any of their officers or employees, unless approved in writing by Administration.

3. Representation of the DISTRICT by a person holding a designated position in any transaction in which he or she or a household member has a personal and/or financial interest.

4. Disclosure or use of confidential, special or inside information of or about the DISTRICT, particularly for personal profit or advantage of the person or a household member of a person holding a designated position.

5. Competition with the DISTRICT by a person holding a designated position, directly or indirectly, in the purchase, sale or ownership of property or property rights or interests, or business investment opportunities.

6. Services for Competitors/Vendors: No person holding a designated position shall perform work or render services for any competitor of the DISTRICT or for any organization with which the DISTRICT does business or which seeks to do business with the DISTRICT outside of the normal course of his/her employment with the DISTRICT without the approval of the Chief Executive Officer or the Chief Operation Officer/Chief Financial Officer of the DISTRICT. Nor shall any such employee be a director, officer, or consultant of such an organization, nor permit his/her name to be used in any fashion that would tend to indicate a business connection with such organization.

B. Prohibited Activities by Persons Holding Designated Positions:

1. In accordance with the DISTRICT'S Policy and unless otherwise authorized by law, no person holding a designated position shall do either of the following:

   a. Possess any ownership interest in any other hospital serving the same area as that served by the district hospital of which the person is a director, policymaking management employee, or medical staff officer.

   b. Be a director or policymaking management employee of any hospital serving the same area as the area served by the district hospital.

2. No person holding a designated position shall serve concurrently as a director or policymaking management employee of the DISTRICT and as a director or policymaking management employee of any other hospital serving the same area as the district, unless the boards of directors of the DISTRICT and such other hospital have determined that the situation will further joint planning, efficient delivery of health care services, and the best interest of the areas served by the respective hospitals.

3. A hospital shall be considered to serve the same area as a district hospital when more than 5 percent of the hospital's patient admissions are residents of the DISTRICT.

IV. Business Relationships Principles

A. Business transactions with vendors, contractors and other third parties shall be transacted free from offers or solicitation of gifts and favors or other improper inducements in exchange for influence or assistance in a transaction.

B. The Standards set forth below are intended to guide employees in determining the appropriateness of the listed activities or behaviors within the context of the DISTRICT's business relationships, including relationships with vendors, providers, contractors, third party payors and government entities. It is the intent of the DISTRICT that this policy be construed broadly to avoid even the appearance of improper activity. If employee has any doubt or concern about whether specific conduct or activities are ethical or otherwise appropriate, the employee should contact Administration.

C. It is the DISTRICT's desire to at all times preserve and protect its reputation and to avoid the appearance of impropriety.

1. Gifts from Patients or Members Personnel and other persons acting on the DISTRICT's behalf shall not offer or give nor shall they accept any bribe, payment, gift or thing of value to or from any person or entity with whom the DISTRICT has or is seeking any business or regulatory relationship except for gifts of a nominal value (not more than $10.00 per item, provided that the total value of gifts from the same source is not more than $50.00 in a calendar year) which are legal and given in the ordinary course of business. Personnel and other persons acting on the DISTRICT's behalf must promptly report the offering or receipt of gifts above a nominal value to their supervisor. California law treats gifts as income and gifts in excess of the nominal value may be required to be reported on the individual's statement of economic interests.

2. Gifts Influencing Decision-making. All employees are prohibited from accepting gifts, favors, services, entertainment or other things of value to the extent that decision-making or actions affecting the DISTRICT might be influenced. Similarly, the offer or giving of money, services or other things of value with the expectation of influencing the judgment or decision making process of any purchaser, supplier, customer, government official or other person by the DISTRICT is absolutely prohibited. Any such conduct must be reported immediately either to the Chief Compliance Officer.

3. Gifts from Existing Vendors: No employees or other persons acting on the DISTRICT's behalf may retain gifts from vendors which have a nominal value (not more than $10.00 per item, provided that the total value of gifts from the same source is not more than $50.00 in a calendar year). If an employee or other persons acting on the DISTRICT's behalf has any concern whether a gift should be accepted, the employee should consult with the Chief Compliance Officer. To the extent possible, these gifts should be shared with the employees' co-workers. Employees shall not

accept excessive gifts, meals, expensive entertainment or other offers of goods or services which have more than a nominal value (not more than $10.00 per item, provided that the total value of gifts from the same source is not more than $50.00 in a calendar year)) nor may employees or other persons acting on the DISTRICT's behalf solicit gifts from vendors, suppliers, contractors or other persons.

D. Contracting: No employee or other persons acting on the DISTRICT's behalf may not utilize "insider" information for any business activity conducted by or on behalf of the DISTRICT. All business relations with contractors must be conducted at arm's length both in fact and in appearance and in compliance with the DISTRICT policies and procedures. Employees and other persons acting on the DISTRICT's behalf must disclose personal relationships and business activities with contractor personnel who may be construed by an impartial observer as influencing the employees' or other persons' acting on the DISTRICT's behalf performance or duties. Employees and other persons acting on the DISTRICT's behalf have a responsibility to obtain clarification from management employees on questionable issues which may arise and to comply, where applicable, with the DISTRICT's conflict of interest policy.

E. Business Inducements: No DISTRICT employee or other persons acting on the DISTRICT's behalf shall not seek to gain any advantage through the improper use of payments, business courtesies or other inducements. Offering, giving, soliciting or receiving any form of bribe or other improper payment is prohibited.

Appropriate commissions, rebates, discounts and allowances are customary and acceptable business inducements provided that they are approved by the DISTRICT management and that they do not constitute illegal or unethical payments. Any such payments must be reasonable in value, competitively justified, properly documented, and made to the business entity to which the original agreement or invoice was made or issued. Such payments should not be made to individual employees or agents of business entities.

V. Protection of Assets Principles

A. Protection of Assets: All employees and other persons acting on the DISTRICT's behalf will strive to preserve and protect the corporation's assets by making prudent and effective use of the DISTRICT resources and properly and accurately reporting its financial condition.

The standards set forth below are intended to guide employees and other persons acting on the DISTRICT's behalf by articulating the DISTRICT's expectations as they relate to activities or behaviors which may impact the

DISTRICT's financial health or which reflect a reasonable and appropriate use of the assets of a public entity.

B. Internal Controls: The DISTRICT has established control standards and procedures to insure that assets are protected and properly used and that financial records and reports are accurate and reliable. All employees and other persons acting on the DISTRICT's behalf share the responsibility for maintaining and complying with required internal controls.

C. Financial Reporting: All financial reports, accounting records, research reports, expense accounts, time sheets and other documents must accurately and clearly represent the relevant facts or the true nature of a transaction. Improper or fraudulent accounting, documentation or financial reporting is contrary to the policy of the DISTRICT and may be in violation of applicable laws.

D. Travel and Entertainment: Travel and entertainment expenses should be consistent with the employee's job responsibility and the organization's needs and resources. It is the DISTRICT's policy that an employee should not suffer a financial loss or a financial gain as a result of business travel and entertainment. Employees and other persons acting on the DISTRICT's behalf are expected to exercise reasonable judgment in the use of the system's assets and to spend the organization's assets as carefully as they would spend their own. Employees and other persons acting on the DISTRICT's behalf must also comply with the DISTRICT's policies relating to travel and entertainment expense.

E. Personal Use of DISTRICT Resources: All officers, employees and other persons acting on the DISTRICT's behalf are prohibited from using DISTRICT resources for private gain. All property and business of the DISTRICT shall be used and conducted in a manner designed to further the interests of the DISTRICT rather than the personal interest of an individual officer, employee or other persons acting on the DISTRICT's behalf. Officers, employees and other persons acting on the DISTRICT's behalf are prohibited from personal use of DISTRICT personnel, equipment, supplies, materials or services.

Questions concerning any aspect of this policy/guideline should be referred to Chief Compliance Officer ~~at 559-685-3816~~.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

CONFLICT OF INTEREST PRINCIPALS

EXHIBIT "A"

Designated Positions*

Designated Positions*	Assigned Disclosure Categories**
Board of Director President	1, 2, 3, 4, 5
Board of Director Vice President	1, 2, 3, 4, 5
Board of Director Secretary	1, 2, 3, 4, 5
Board of Director Treasurer	1, 2, 3, 4, 5
Board of Director Member	1, 2, 3, 4, 5
Legal Counsel	1, 2, 3, 4, 5
Chief Executive Officer	1, 2, 3, 4, 5
Chief Operations Officer	1, 2, 3, 4, 5
Chief Financial Officer	1, 2, 3, 4, 5
Chief Compliance Officer	1, 2, 3, 4, 5
Chief Nursing Officer	1, 2, 3, 4, 5
Chief Information Officer	1, 2, 3, 4, 5
VP, Rural Health Clinics	1, 2, 3, 4, 5
Patient Access Director	1, 2, 3, 4, 5
Case Management Director	1, 2, 3, 4, 5
Construction Management Director	1, 2, 3, 4, 5
Finance Director	1, 2, 3, 4, 5
Home Care Director	1, 2, 3, 4, 5
Human Resources Manager	1, 2, 3, 4, 5
Laboratory Director	1, 2, 3, 4, 5
Materials Management Director	1, 2, 3, 4, 5
Medical Imaging Director	1, 2, 3, 4, 5
Health Information Management Director	1, 2, 3, 4, 5
Medical Staff Director	1, 2, 3, 4, 5
Clinical Director's	1, 2, 3, 4, 5
Pharmacy Director	1, 2, 3, 4, 5
Plant Operations Director	1, 2, 3, 4, 5
Respiratory Care Director	1, 2, 3, 4, 5
Retail Pharmacy Director	1, 2, 3, 4, 5
Consultants***	1, 2, 3, 4, 5

***Consultants shall receive a copy of the DISTRICT Conflict of Interest Policy and be responsible for thoroughly reviewing the policy and shall thereafter, submit a signed acknowledgement that he/she has reviewed the policy, and attest that he/she has no disclosable conflicts. In the event the Consultant does have a disclosable conflict, he/she shall be responsible for promptly disclosing all such conflicts to the CEO or his/her designee.

Descriptive Name:	Principles of Compliance
Descriptive Type:	Revised
Document Number:	10-1002.8
Attachments:	Exhibit A
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, Chief Compliance Officer
Typist:	~~Julie Gresham~~Andrea Carrasco/Ena Menezes
Creation Date:	09/23/09
Revision Date:	~~04/01/14~~ 02/01/18
Prev. Dist. Date:	04/25/13

Committee Review and Approval:	Approval Date:	Comments:
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Board of Directors	~~06/25/14~~	

Effective Date:	~~06/26/14~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Physician Referral and Anti-Kickback Policy and Procedure

PURPOSE:

To define the DISTRICT's policy concerning physician relationships and provide guidelines for compliance with the applicable laws.

POLICY:

In order to provide quality health care to members of our community, the DISTRICT conducts business with a number of different physicians. The DISTRICT's interaction with physicians can affect a variety of issues, including the anti-kickback law, the IRS rules on independent contractor status, and the "Stark II" self-referral law. The DISTRICT is committed to complying with all applicable laws in the relationships with physicians, maintaining the highest ethical standards, and ensuring that the physicians practicing at the DISTICT's facilities also adhere to the highest ethical standards.

PROCEDURE:

1. **The Stark II Self Referral Law**
   The Stark II self-referral law prohibits physicians from referring patients to the DISTRICT's facilities for certain health services for financial gain or interest if the physician or a physicians' family member has a financial relationship with the DISTRICT. A financial relationship can include an ownership or investment interest or a compensation arrangement.

2. **The Anti-Kickback Law**

   The Anti-Kickback Statute is a federal law which prohibits health care providers and suppliers from giving or receiving "remuneration" in exchange for the referral of patients or services covered by most federal health programs, such as Medicare and Medicaid. A violation involves "knowingly and willfully" offering, paying, soliciting or receiving prohibited remuneration. Remuneration not only includes cash payments for referrals, but also other benefits, such as loan forgiveness, gifts, discount leases and other acts.

Kickback in construction law means any money, fee commission, credit, gift, gratuity, thing of value or compensation of any kind that is provided directly or indirectly to any prime contractor, prime contractor employee, subcontractor or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contractor in connection with a subcontract relating to a prime contract.

Physicians, personnel and other persons acting on the DISTRICT's behalf shall not offer or give nor shall they accept any bribe, payment, gift or thing of value which might appear to influence the actions of the physician or from any person or entity with whom the DISTRICT has or is seeking any business or regulatory relationship except for gifts of a nominal value (not more than $10.00 per item, provided that the total value of gifts from the same source is not more than $50.00 in a calendar year) which are legal and given in the ordinary course of business. Personnel and other persons acting on the DISTRICT's behalf must promptly report the offering or receipt of gifts above a nominal value to their supervisor.

Compliance with these policies is a required condition of employment or continued engagement with the DISTRICT. Violations of these policies should be reported in accordance with the DISTRICT's Reporting Policy.

3. **Independent Contractors**
   All agreements with physicians must be reviewed by the Chief Compliance Officer and Legal Counsel for the District. The Chief Compliance Officer will review all agreements with physicians in order to ensure the independent contractor relationship in light of the relevant IRS guidelines.

4. **Informing the Public about Independent Contractors**
   In order to ensure that the public is informed about independent contractors and to avoid liability for the acts or omissions of independent contracts, all such arrangements with independent contractors must be reviewed by the Chief Compliance Officer and Legal Counsel for the District. Conditions of admission forms include a notice disclosing which goods or services are provided by independent contractors. The form of such notices should be reviewed by Legal Counsel to the DISTRICT.

5. **Private Benefit/Private Inurement**
   The DISTRICT may not engage in activities primarily serving private interests and may not enter into agreements in which the profits of the DISTRICT pass to "insiders" such as physicians. The DISTRICT may not pay physicians unreasonable or excessive compensation, whether the compensation is for goods or services. This information may generally be obtained through compensation surveys (fair market values) and similar materials. All transactions involving physicians must be approved by Chief Compliance Officer and Legal

Counsel for the District. Employees or other persons acting on the DISTRICT's behalf, who learn of activities or arrangements which may involve excessive or unreasonable compensation or other substantial private benefit or private inurement must report their concerns to the Chief Compliance Officer in accordance with the DISTRICT's Reporting Policy.

6. **Contracting with Excluded Physicians**
   As federal law prohibits the DISTRICT from contracting with physicians who are excluded from participation in Medicare and other federal health care programs, all agreements with physicians must be reviewed by the Chief Compliance Officer. The Chief Compliance Officer will conduct background checks in accordance with the DISTRICT's Screening Policy.

7. **Reassignment of Medicare Benefits**
   Medicare benefit payments for physician services may normally only be paid to the physician providing services or to the Medicare beneficiary. These benefit payments may, however, be assigned to the DISTRICT. When the physician is an independent contractor, in order for the DISTRICT to receive payment for the physician's services, the services must be provided within the DISTRICT's health care facilities, and the physician must sign an agreement whereby the DISTRICT submits the bill for the services.

   All arrangements involving reassignment to the DISTRICT of Medicare benefit payments for physician services must be reviewed by the Chief Compliance Officer and Legal Counsel for the District in order to ensure compliance with an appropriate exception. Suspected violations of the reassignment rules should be reported to the Chief Compliance Officer in accordance with the DISTRICT's Reporting Policy.

8. **Physician Recruitment**
   All agreements involving physician recruitment incentives, whether in the form of income guarantees, office space, professional services, or equipment, must be reviewed by the Chief Compliance Officer and Legal Counsel for the DISTRICT. The recruitment incentives should be structured so as to minimize risks of violating the Stark II self-referral law, Anti-kickback law and all applicable laws in order to avoid jeopardizing the DISTRICT.,

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Physician Referral and Anti-Kickback Policy and Procedures
Descriptive Type:	Revised
Document Number:	10-1002.9
Attachments:	None
Author:	Rachele Berglund Bailey, General Legal Counsel Julie Gresham, Chief Compliance Officer
Typist:	~~Julie Gresham~~Andrea Carrasco/Ena Menezes
Creation Date:	09/23/09
Revision Date:	~~04/01/14~~ 02/01/18
Prev. Dist. Date:	04/25/13

Committee Review and Approval:	Approval Date:	Comments:
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Board of Directors	~~06/25/14~~	

Effective Date:	~~06/26/14~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Solicitations and Distribution of Literature on Hospital Property

In an effort to avoid disruption of health care operations or disturbance of patients, patient visitors, hospital employees and volunteers, the following rules shall apply to solicitations and/or distribution of literature on hospital property:

1. Definitions

   A. "Working time" includes the working time of both the employee doing the soliciting and/or distributing and the employee to whom soliciting and/or distributing is directed. Working time does not include break periods, meal times or other specified periods during the workday when employees are properly not engaged in performing their work tasks.

   B. "Immediate patient-care areas" include, but are not limited to, patient rooms, operating rooms, rooms used by patients for consultations with physicians and places where patients receive treatments such as x-ray, therapy, and like areas.

   C. "Working areas" are all areas in the hospital except the cafeteria, gift shop, employee lounge, lobbies and parking areas.

2. Solicitation

   A. Employees of Tulare Local Health Care System may not solicit during the working time of the employee doing the soliciting, or the employee to whom soliciting is directed, for any purpose.

   B. Employees of Tulare Local Health Care System may not solicit at any time for any purpose in immediate patient-care areas or in working areas.

3. Distribution of Literature

A. Employees of Tulare Local Health Care System may not distribute literature during working time for any purpose.

B. Employees of Tulare Local Health Care system may not distribute literature at any time for any purpose in working areas.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy replaces or supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Solicitations and Distribution of Literature on Hospital Property
Descriptive Type:	Revised
Document Number:	10-1005
Attachments:	None
Author:	Robert Kelley/Kris B. Pedersen
Typist:	~~Melissa Arend~~Andrea Carrasco/Ena Menezes
Creation Date:	05/23/02
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Board of Directors	~~11/19/14~~	

Effective Date:	~~11/20/14~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Guidelines for Vendor Representatives in the Hospital

I. Policy Statement:

The purpose of this policy is to assure appropriate visitation by representatives and vendors at Tulare Regional Medical Center locations including the main hospital and clinics.

II. Intent and Scope:

A. The primary objective is to minimize interruptions to Tulare Regional Medical Center's personnel, provide tracking of evaluation products, promote standardization of products and establish vendor policy compliance.

1. <u>General Information:</u>

a. Tulare Regional Medical Center is committed to patient care to the highest level.

b. HPG is the Group Purchasing Organization (GPO) utilized by Tulare Regional Medical Center.

c. Vendor Mate is the Vendor Credentialing Organization utilized by Tulare Regional Medical Center. It is mandatory for all vendor representatives visiting Tulare Regional Medical Center to be cleared through Vendor Mate before entering this facility with the following exceptions;

1. Delivery agents, service technicians

d. All vendor representative will report to any Vendor Mate Kiosk and log into Vendor Mate to print a badge prior to all visits within the hospital. Any vendor representative that is denied access to this facility through Vendor Mate is required to report to the Purchasing Department to speak with designee.

1. Information required on Vendor Mate includes:

i. Approximate Visit Length

ii. Name of Tulare Regional Medical Center employee to be met – Be Specific

iii. Meeting Location

iv. Meeting Note – Purpose of representative visit.

e. The badge must be worn at all times while on hospital property.

f. The badge cannot be reused.

g. Appointments will be at convenience of hospital personnel.

h. Vendor representatives in procedural patient care areas to include but not limited to the Operating Room, Catheterization and Vascular Lab, Endoscopy, and Radiology, who come to the hospital to provide technical product support on cases or have direct patient contact must:

1. Provide (into the online vendor system) the following immunization and training documentation:

i. TB skin test or, if positive, documentation of chest X-Ray

ii. Competency assessment for the product or service being provided

iii. Vendors representatives will NOT be permitted in the OR control desk area, surgeon's lounge or staff lounge (unless express permission is given by the Director of Peri-Operative and Surgical Services, Surgeon, or the OR Coordinator.

iv. Vendor representatives will NOT scrub in surgery.

v. Vendor representatives will conduct their business in a timely manner.

i. Vendor representatives that are Medical Equipment Service personnel are required to maintain the following documents in the online vendor system:

1. TB skin test or, if positive, documentation of chest X-Ray
2. Competency assessment for the product or service being provided

j. Vendor representatives that are Medical Equipment Service personnel are required to maintain the following documents in the online vendor system:

1. TB skin test or, if positive, documentation of chest X-Ray

2. Competency assessment for the product or service being provided

k. Vendor representatives will electronically acknowledge this policy via the "TRMC Vendor Program" system. This acknowledgment will also include "The Vendor Code of Conduct (Attachment A).

2. **Clinical & Nonclinical Representatives/Vendors:**

a. Department Managers are to notify the Material Management Director of any new clinical products under consideration.

b. The Material Management Director will coordinate a review of product.

c. Clinical sales representative must present unsolicited new products to the material Management Director and/or designee prior to showing

3. **Pharmeceutical Representatives:**

a. Specific drugs shall be promoted or in-serviced at only with the acknowledgement of the Pharmacy Director (or designee). Any in-services provided must be approved in writing by the Pharmacy Director (or designee). Written requests for approval of in-services must be submitted at least [4 weeks] prior to the in service date and include the audience, time, place, and program content.

b. Pharmaceutical representatives conducting any business must first register with the TRMC Vendor Program's on-line vendor system before proceeding to any appointments at TRMC.

c. After exclusion of a drug product from the Hospital, that product may no longer be promoted unless written consent has been obtained from the Pharmacy Director or designee. Consent must be requested in writing and information on how the product will be promoted must be provided.

d. Pharmaceutical sales representatives shall not leave drug samples. Drug samples are not authorized anywhere in the facility or it's entities.

e. Violation of the policy will be documented by the TRMC employee online vendor system and that vendor is subject to corrective actions by the hospital based on the degree of violation which may include loss of vendor privileges.

4. Service Representatives:

a. Service representative include any visitors not in the business of selling equipment or supplies.

b. Service representatives must follow the same identification procedure as outlined under General Information.

c. Service representative will follow the same guildelines as sales representative, where applicable.

5. Department Visitation:

a. No vendor sales or solicitation will be conducted in any department without a previously arranged appointment. All visitors to sterile areas require physician and/or Team Leaders or Department Manager approval.

b. The vendor representatives will make an appointment with the interested physician in their office.

c. Vendor and service representative are authorized to visit only the designated area indicated on the visitor log. The vendor representative will leave the area when finished and will not visit other areas except by request and/or approval of the Material Management Department.

d. On arrival to the department, the vendor representative must announce themselves to the supervisor.

e. Vendor representatives are not allowed in supply areas without appropriate hospital escort.

f. **No vendor is to remove any item (inventory / instrumentation / consignment) from Tulare Regional Medical Center without permission from the Director of Material Management and/or designee. If any item is removed without permission, it will be considered theft and will be punishable to the full extent of the law.**

g. All new products must be approved and the appropriate education/training conducted prior to hospital use.

h. All electrical equipment for purchase, loan, evaluation, rent or lease must be cleared by the Biomedical Department prior to use.

i. No vendor representatives will operate any clinical equipment or use any clinical supply affecting patient care during a procedure. He/she may give verbal direction or demonstrate with a like item off the field.

j. Infection Control protocols will be followed.

k. Tulare Regional Medical Center is a smoke free and tobacco free campus.

6. <u>Bid, Contract and Pricing Information:</u>

a. All information pertinent to bidding or contract award will be obtained from the Director of Material Management at the beginning of the requisition process.

b. Where appropriate, a minimum of two sources will be reviewed.

c. All information pertinent to bidding, contracts and costs are confidential.

d. With the exception to supplies ordered by Nutritional Services and Pharmaceutical Services, all requisitions for purchases are validated and verified by the Director of Material Management or designee.

e. All approved purchases must have an authorized purchase order number.

7. <u>Purchase Requisitions/Purchase Orders:</u>

a. A Special Purchase Requisition is required for any acquisition not itemized in the Material Management Information System.

b. Any products received in the normal course of business without prior departmental approval and Materials Management authorization as evidenced by an issued purchase order by Tulare Regional Medical Center are not considered the responsibility or liability of Tulare Regional Medical Center.

c. All supplies or equipment to be used on a patient, for any reason, must have a purchase order reference number, whether or not there is a cost. There also must be specific information such as the

manufacture's product number, quantity, description of the product and the expected price.

d. Supplies for surgery that are used for off-hour emergency cases will need to progress through the approval process. Purchase requisitions for these cases are to be submitted to the Director of Perioperative Services.

e. Any product or equipment that is brought in for patient use without prior documented approval will be considered a donation from that company and the patient and/or Tulare Regional Medical Center will not be charged for the item.

NOTE: Requisitions will become purchase orders when all approvals are met and a purchase order is created.

8. Loaner Instrument Sets:

a. Instruments sets must arrive 24 hours prior to scheduled use for proper sterilization.

b. The Sterile Processing Department will inventory all loaner instrument sets at the time of delivery to Surgery. The signature of the Sterile Processing Department and/or the company representative must be on the log verifying that the set is complete. The log must also reflect when the representative retrieved the set. The Sterile Processing Department will inventory the set prior to sending it out. Tulare Regional Medical Center is not liable for sets that have not been documented in the log.

9. Confidentiality:

a. Representatives will keep all patient information **CONFIDENTIAL** and will not disclose or reproduce such information for any purpose. Certain patient information is protected by fines and penalties imposed by Federal and State Laws. The representative is bound by this policy at all times during and after their visit to Tulare Regional Medical Center and any entities thereof.

10. Violations:

a. Failure on the part of the representative to comply with the above stated policy and procedures:
1. First offense: will result in a verbal warning.

2. Second offense: will result in a verbal warning to representative and their respective manager.

3. Third Offense: will result in temporary suspension of visiting privileges for a period of not less than 30 days.

4. Forth Offense: will result in permanent loss of all visiting privileges.

11. **GIFT & GRATUITIES:**

See the TRMC Standards of Ethical Conduct and Code of Conduct (10-1002.1)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT "A"

VENDOR CODE OF CONDUCT

Tulare Regional Medical Center and its entities, expect vendor representative's to be ethical in your conduct. You are required to carefully follow all laws and regulations, and have the highest standards of conduct and personal integrity.

You are required to conduct yourself in such a way as to protect the interest and safety of patients, employee's and Tulare Regional Medical Center and it's entities.

Any vendor representative that breaks this code of conduct will be subject to disciplinary action*.

While it is impossible to list every action that is considered unacceptable conduct, the following lists some examples:

- Theft or inappropriate removal or wrongful possession of property.
- Working under the influence of alcohol or illegal drugs.
- Possession, distribution, sale, transfer, or use of alcohol or illegal drugs in the hospital or its entities.
- Fighting or threatening violence in the hospital or its entities.
- Boisterous or disruptive behavior in the hospital or its entities.
- Disrespectful conduct.
- Violation of health or safety rules.
- Smoking or use of tobacco products on TRMC campus.
- Sexual or other unlawful or unwelcome harassment.
- Gambling or possession of weapons in the hospital or its entities.
- Unauthorized use of hospital telephones or Internet.
- Disclosure of confidential patient or business information.
- Dishonesty
- Unsatisfactory performance or conduct.
- Interference with business or production, efficiency, or in competency**.

* Vendor disciplinary actions may include: Verbal warning, Written warning with a copy sent to the representative's manager, restricted visiting privileges and/or being barred from the facility; this could be temporary or permanent.

** This includes casting disparaging remarks "bad mouthing" other companies that conduct business with Tulare Regional Medical Center.

Descriptive Name: Guidelines for Vendor Representatives in the Hospital

Descriptive Type: Revised

Document Number: 10-1006

Attachments: None

Author: Celeste Terronez

Typist: Celeste Terronez

Creation Date: 03/07/12

Revision Date: 1/17/18

Prev. Dist. Date: 10/24/07

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Comm. (EOC)	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Visitation

I. POLICY:

A. Patient's (or support person, where appropriate) shall be informed of his or her visitation rights, including any clinical restriction or limitations on such rights, in advance of furnishing patient care whenever possible.

B. Each patient (or their support person, where appropriate) has the right to receive visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such designation at any time.

C. TRMC shall not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender, identity, sexual orientation or disability.

D. Visitors shall enjoy full and equal visitation privileges consistent with the patient's preferences.

E. In an effort to insure sufficient patient visitation time the following patient visiting policy is established:

II. VISITATION AND VISITATION HOURS:

A. Routine standard visiting hours shall be from 11:00 a.m. to 8:00 p.m.

B. Visitors must obtain a visitor pass from Security located in the main Hospital entrance from 06:00 a.m. to 08:00 p.m. or Emergency Department after 08:00 p.m.

C. Children (for purposes of visitation is under 18 years of age) under direct adult supervision may visit in all areas except patient's in isolation. Further restrictions may apply during the Influenza season.

D. A maximum of two visitors per patient may visit at any one time. For the Intensive Care Unit, see Section 3b.

E. Prior to visiting hours, visitors may wait in designated waiting areas of the hospital. (They may not wait in any patient areas including hallways.)

F Critically ill patients or patients with special needs may receive visitors at times other than standard visiting hours when coordinated with the patient's nurse.

G. Clergy are not considered visitors in the normal sense of the word. Visits to their church members shall be facilitated whenever possible. If patient care is in progress (such as baths, baby feedings), they should be informed and given a reasonable alternative visiting time. This includes OB and ICU.

H. Overnight arrangements can be made for visitors as requested by patients or family with the concurrence of the patient's nurse or by physician order and only when a private room is available. Overnight guests must be 18 years of age.

I. All visitors must wear appropriate attire, including shoes, even if they do not enter patient areas.

J. Visitors may, if they wish, take their meals in the patient's room

1. Dining Room meal hours for visitors are:

Breakfast	7:00 a.m. – 9:00 a.m.
Lunch	11:00 a.m. – 1:00 p.m.
Dinner	5:00 p.m. – 8:30 p.m.

K. Visitors may not bring food or liquids to the patient unless coordinated with and approved by the patient's nurse.

L. Pets do not qualify as visitors. However, if Patient and Family Services or Physician certifies that it is critical to the patient's well being to visit with a pet, arrangement may be made to do so. See Hospital Policy #20-8028 Service Animals and Personal Pet Visitation Guidelines.

III. VISITATION IN SPECIAL CARE AREAS:

A. Obstetrics/Nursery - Refer to the Birthplace – Visiting Policy #10-1008.1.

B. Intensive Care Unit:

1. Visitation is limited to two visitors at a time for and may be restricted at the nurse's discretion. (There are no specific hour restrictions).

2. Nurse has discretion to limit visitation **if** such visitation interferes with delivery of patient care.

C. Isolation:

1. With special precautions and requirements.

D. Recovery Room:

1. No visitors allowed.

E. Pre-Surgery and/or Surgical:

1. Immediate family may see patients before surgery.

2. Family may wait in the Outpatient Services (ACU) lobby or second floor waiting room during surgery.

3. Family will be notified of patient's arrival in Recovery Room and on return to Outpatient Services or to the patient's room.

F. (Med Surg 3 (Pediatrics):

1. Parents or guardians are encouraged to stay as much as possible to ensure the child's sense of security.

2. Recliners are available for those parents wishing to spend the night.

3. Complimentary guest meals shall be provided to the parent(s) or designee who stays with the patient.

G. Emergency Department

1. Due to limited space in the Emergency Department patient areas, only one visitor per patient treatment room will be allowed. Nurse has discretion to limit visitation if such visitation interferes with patient care.

Tulare Regional Medical Center, its Medical Staff, Staff, Administration and Governance all recognize the inherent importance visitation plays in a patient's comfort and/or recovery. At the same time, on occasion limitations on visitation up to and including restricting

visitation consistent with the patient's wishes. As such, the attending physician and nurse have a right to exempt provisions of this visitation policy as necessary to perform essential duties in the pursuit of patient care. This right to exempt shall not be applied arbitrarily, capriciously or indiscriminately.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Visitation

Descriptive Type: Revised Policy

Document Number: 10-1008

Attachments: None

Author: Julie Gresham/ Andrea Carrasco/Ena Menezes-

Typist: Julie Gresham

Creation Date: 09/27/07

Revision Date: ~~08/21/14~~ 02/01/18

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Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	~~08/21/14~~	
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments and Medical Staff

FROM: Administration

SUBJECT: The Birthplace - Visiting Policy

ANTEPARTUM/INTRAPARTUM

1. Subject to the discretion of the attending physician and nurse(s) and to reasonable physical space limitations, a laboring mother may have with her those coaches of her choice who are prepared and willing to be supportive of her during her labor and delivery (2 coaches only in most cases). Casual visiting is not appropriate during labor.

2. Support persons can be requested to leave at any time by the physician or the nurses.

POSTPARTUM

1. The mother may designate one (1) person who can come in to be with her at any time, except in non-private rooms after 8:00 p.m.

2. All other visitors are requested to visit during normal hospital visiting hours and subject to normal hospital visiting guidelines.

3. Before entering the birthplace, you will need to use the phone to obtain current visitation status of the patient.

4. All visitors must check in at the nurses' station.

5. Children 12 and under are not permitted (with the exception of siblings for a brief visit).

6. All postpartum visitors should be requested by the patient and/or staff to wash their hands before touching the infant.

7. Babies will be shown to family members for the first time after delivery at any hour. If the birth should occur when other patients are normally asleep, visitors will be asked to keep the visit brief and quiet in consideration of others.

8. No visitor who is ill should consider visiting a new mother and baby.

Effective Date: (10) Administration/Medical Staff General:

APPROVED: The Birthplace – Visiting Policy 10-1008.1

Medical Executive Comm.:

Board Of Directors:

NURSERY

1. Visiting in the nursery is allowed to parents of those infants who are unable to be with the parents in a normal patient room. If neither parent is able to visit with the baby, one (1) alternate may be designated with the prior approval of the infant's attending physician. Unusual circumstances will be dealt with on a case-by-case basis with the agreement of the attending physician.

2. Grandparents may visit in the nursery only if they are accompanied by a parent. (Only two total visitors at a time – so one parent with one grandparent may visit.)

3. Parents and Grandparents who visit with their infants in the nursery shall be infection free and shall scrub in and gown.

4. Parents of boarder babies are encouraged to visit at any time and participate in the care of their infants as appropriate. Provisions will be made to facilitate breast-feeding.

5 Visitors who wish to view the infants are requested to visit during normal hospital visiting hours.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: The Birthplace – Visiting Policy

Descriptive Type: Revised

Document Number: 10-1008.1

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 08/25/11

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OB/Pediatric Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Disruption or Discontinuance of Hospital Service(s)

In an effort to designate and to facilitate an orderly plan to be implemented should there ever be a disruption of hospital services or for any reason a discontinuation of service(s), the Hospital CEO or his/her designee shall be responsible for notifying each department and coordinating the reaction to the discontinuance or disruption of service(s).

In accordance with Section with Section 70746 of the Hospital Licensing Regulations, "The Administrator shall be responsible for informing the Department Public Health Services, Licensing and Certification, via telephone, (Bakersfield District Office: Telephone (661) 336-0543), immediately upon being notified of the intent of the discontinuance or disruption of services or upon the threat of a walkout of a substantial number of employees, or earthquake, fire, power outage, or other calamity that causes damage to the facility, or threatens the safety or welfare of the patients or clients."

The reactional decision to discontinuance or disruption of services may include:

1. Initiation of the Hospital Incident Command System (HICS).

2. Evacuation of patients.

3. Initiation of Fire Plan.

4. Utilization of alternative staff to continue the functional operation of the Department(s).

5. Importation of Staff and/or equipment and/or supplied and/or other provisions.

6. Transfer of patients and/or staff to other facilities.

7. Closure of a department.

All decisions to effect the implementation of any of the above alternatives will be made through the Administrator or his/her designee and will be made in an orderly expeditious manner.

Board of Directors: ~~04/22/09~~ 10-1009

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Disruption or Discontinuance of Hospital Service(s)

Descriptive Type: Revised

Document Number: 10-1009

Attachments: None

Author: Julie Gresham/Andrea Carrasco/Ena Menezes

Typist: Julie Gresham

Creation Date: 03/09/09

Revision Date: 02/01/18

Prev. Dist. Date: 10/26/06

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~03/16/09~~	
Board of Directors	~~04/22/09~~	

Effective Date: ~~04/23/09~~

Forward To: Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

To: All Employees, Contracted Staff, Medical Staff, Volunteers, Patients, Visitors and Vendors

From: Administration

Subject: Tobacco-Free Policy

I. Purpose:

To provide appropriate guidelines regarding Tulare Regional Medical Center's commitment to providing a safe and healthful work environment for all employees, contracted staff, medical staff, patients, visitors and other customers.

Smoke inhaled from direct smoking as well as indirectly from other's who are smoking nearby, is a major cause of preventable disease and death.

TRMC serves as a model for our community in the area of promoting the good health of our staff and influencing public attitudes about smoking or using tobacco products. It is, therefore, TRMC's policy to provide a totally tobacco-free environment. TRMC is committed to providing helpful intervention strategies and treatment resources in addressing this issue and to offering programs and smoking cessation assistance for employees, contracted staff, medical staff and patients to reduce their dependence on tobacco products.

II. Policy:

A. **Effective January 1, 2012**, it is the policy of TRMC to provide a safe, healthful and comfortable work environment for all employees, contracted staff, patients, visitors and physicians by prohibiting smoking or using tobacco products in the workplace. TRMC believes that a tobacco-free policy is consistent with our leadership role in the health care field and contributes to employee wellness and productivity.

B. Employees, contracted staff, patients, visitors and physicians are prohibited from smoking or using any tobacco products on or in TRMC main hospital and other hospital campus buildings, adjacent grounds, including parking lots and TRMC owned or leased vehicles. Employees, contracted staff, patients, visitors and physicians may not smoke or use tobacco products in their own or others' vehicles when the vehicles are on TRMC's property.

Effective Date: ~~11/20/14~~

(10) Administration General: Tobacco-Free Policy 10-1013

APPROVED:

Medical Executive Comm.: ~~11/05/14~~

Board Of Directors: ~~11/19/14~~

III. General:

A. Scope:

1. This policy applies to all TRMC employees, contracted staff, visitors, patients, physicians and customers and is in effect 24 hours a day. As a leading provider of healthcare services in Tulare County, TRMC is committed to the prevention of disease and the promotion of good health. Smoking and tobacco use has been clearly identified as a major contributor to heart, lung, and other disease entities, through both direct and indirect exposure.

B. Definition:

1. Smoking is defined as carrying, holding or using a lighted cigarette, cigar, electronic cigarette or pipe of any kind or emitting or exhaling smoke of any kind.

2. Tobacco is an agricultural product processed from the leaves of plants in the genus *Nicotiana*. It is most commonly used as a recreational drug, and is a valuable cash crop for countries such as Cuba, China and the United States. It most commonly appears in the forms of smoking, chewing, snuffing, or dipping tobacco.

IV. Procedure:

A. TRMC's security may be called for additional support.

B. TRMC is committed to providing helpful intervention strategies and treatment resources in addressing this issue and to offering programs and smoking cessation assistance for current employees and patients to reduce their dependence on tobacco products.

C. Individuals located in buildings off-campus, which are not owned by TRMC, will abide by the smoking policy of the particular building in which they reside.

V. Hospital Employees and Contracted Staff:

A. Lack of employee and contracted staff cooperation or repeated violations shall be reported to Human Resources. Human Resources will contact the individual's department director or the contracted services director who will address the issue.

B. Standard disciplinary procedures will be followed for compliance problems with employees. Violations will result progressive disciplinary actions, up to and including termination.

C. New employees and new contracted staff will be informed of TRMC's tobacco-free policy during the new hire process and during hospital orientation.

D. All personnel are responsible for adherence to and enforcement of the tobacco-free policy.

VI. **Medical Staff:**

A. New Medical Staff members will be informed of the hospital's tobacco-free policy appointment and during orientation to TRMC.

B. Tobacco use by physicians within hospital or in other violation of this policy will be reported to the respective departmental chairperson for appropriate action under the medical staff bylaws.

VII. Patients and non-employee persons on the campus:

A. Patients will be provided with education regarding the tobacco-free policy upon admission.

B. Patients will be provided with education regarding the benefits of and resources for smoking cessation.

C. Staff will notify patient's physician to request smoking cessation aids if needed for the patient.

D. Staff and Security personnel will educate and counsel patients and non-employee persons on campus if tobacco use violations are observed, respectfully requesting their compliance; however, the policy will be strictly enforced.

E. Tobacco use by patients will be reported to the respective patient care unit or departmental leadership
.

F. Tobacco use by visitors may require a friendly reminder by hospital staff or notification of the security department. However, the policy will be strictly enforced.

G. TRMC security and/or administration/administrator on-call shall be notified as the final resource to resolve problems arising with visitors or patients during the enforcement of this policy.

H. Violations of this policy by patients or non-employee persons on campus will be reported through the occurrence reporting process (Quality Review Report (QRR).

VIII. Management Staff (Includes Managers, Supervisors, Coordinators and other Supervising Staff):

A. Ensure employee compliance and enlist employee support in accomplishing TRMC's commitment to a tobacco-free campus and workplace.

IX. Smoking Cessation Assistance:

A. Tobacco free California offers no cost resources to help you quit smoking at www.tobaccofreeca.com. 1-800-no-butts is a smoking cessation hotline that offers counseling free of charge.

B. Prescription medication may be obtained from a physician.

X. Communication and Enforcement:

A. All personnel are responsible for adherence to and enforcement of the tobacco-free policy. Violations of this policy by employees will be addressed through the performance improvement process, as follows:

- First Violation: Verbal Warning
- Second Violation: Written Warning
- Third Violation: Counseling by Human Resources
- Fourth Violation: Suspension
- Fifth Violation: Termination

XI. Human Resources:

A. Inform applicants for employment that TRMC maintains a tobacco-free workplace.

B. Assist Management Staff in policy compliance matters.

XII. Education Department:

A. Education Department will be responsible for educating staff and contracted staff regarding TRMC's tobacco-free Policy during orientation and reinforcement education during annual update.

XIII. Monitoring:

A. The Environment of Care Committee will evaluate compliance with this policy through periodic monitoring of incidence of violations and will make recommendations for strategies to eliminate violations when necessary.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive name: Tobacco-free Policy

Descriptive type: Revised

Document number: 10-1013

Attachments: None

Author: Lionel Machado

Typist: ~~Melissa Arend~~

Creation Date: 10/26/06

Revision Date: ~~08/21/14~~ 01/16/18

Prev. Dist. Date: 12/08/11

Committee review and approval:	Approval date:	Comments:
EOC committee	~~08/21/14~~	
MEC	~~11/05/14~~	
Board of Directors	~~11/19/14~~	

Effective date: ~~11/20/14~~ ~~1/16/18~~ 11/20/14

Forward to: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba(Tulare Regional Medical Center~~District HealthCare System) (TDHS)~~

POLICY/GUIDELINE MANUAL

TO: All Departments and Auxiliary

FROM: Administration

SUBJECT: Patients Temporarily Leaving Patient Care Unit/Or Hospital Grounds

This policy is established out of concern for our patients' safety when temporarily leaving the patient care unity unaccompanied for personal reasons.

Patients requesting to temporarily leave the patient care unit for personal reasons shall sign the "Leaving the Patient Care Unit" form releasing the hospital, its employees, physicians and agents from all responsibility for any injury or ill effects resulting from this action. A written doctor's order is required before this action may be taken.

Please refer to Smoking Policy #10-1013.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Board of Directors: ~~5/22/02~~

Leaving the Nursing Care Unit
~~(Not Hospital Grounds)~~

Patient's Name: _____

Whenever I am temporarily leaving the nursing care unit for my personal need during this hospitalization, I hereby release the doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects which may result from this action. A written doctor's order is required before this action may be taken.

Date: _____ Time: _____ A.M. / P.M.

Signature: _____
Patient / Parent / Conservator / Guardian

If signed by other than patient, indicate relationship: _____

Witness: _____

Descriptive Name:	Patients Temporarily Leaving Patient Care Unit
Descriptive Type:	Revised ~~1/2018~~
Document Number:	10-1013.1
Attachments:	None
Author:	Peggy Bryant/Andrea Carrasco/Ena Menezes
Typist:	Debra Campbell
Creation Date:	6/22/01
Revision Date:	~~—~~ 01/16/18
Prev. Dist. Date:	3/30/94
Revision Notes:	MEC 5/8/02 General Board 5/22/02
Effective Date:	~~5/23/02~~ ~~1/2018~~ 05/23/02
Forward To:	Policy Binders –
Disposition:	Copy and Distribution – Debra Campbell
Comments:	
Date Completed:	~~5/24/02~~ ~~1/2018~~ 05/24/02

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Hospital Departments

FROM: Administration

SUBJECT: Risk Assessment Policy

POLICY

It is the policy of Tulare Local Health Care District to conduct a Risk Assessment of the Environment of Care® (EC) on at least a tri-annual basis.

PURPOSE

The risk assessment is used to evaluate the impact of the environment of care on the ability of the organization to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals.

RESPONSIBILITY

The Chairperson of the EOC Committee in conjunction with the Safety Officer is responsible for managing the risk assessment process. The responsibilities include:

1. Participating in the selection of Risk Assessment Team members
2. Training team members
3. Scheduling departmental and area assessments
4. Managing the annual assessment of the scope of the Environment of Care programs

PRACTICE

A risk assessment of all existing programs will be conducted as part of the current annual evaluation of the EC programs. The risk assessment will be reviewed during each subsequent annual evaluation.

A risk assessment of all new services and of all areas undergoing major renovation, alteration, or conversion will be conducted prior to use.

Board of Directors: ~~04/22/06~~

The risk assessment findings will be used as a data source for Environmental Tours (Formally Hazard Surveillance). The risk assessment will be submitted to the EC Committee.

INITIAL RISK ASSESSMENT/REEVALUATION OF RISK ASSESSMENT

This procedure describes the actions required to initiate and conduct an initial risk assessment and the actions required to reevaluate a risk assessment as part of the annual evaluation of the EC programs.

1. A. An initial risk assessment is required for all areas not having had a risk assessment conducted within the last 3 years.

   B. An initial risk assessment is required whenever a new building is constructed, or if the hospital purchases an existing building or an area undergoes significant renovation or conversion of use.

2. A. Each department or area requiring an initial risk assessment or Reevaluation of risk assessment is evaluated using an appropriate risk assessment form(s).

   B. The evaluator completes the form by identifying the risks related to the environment and the activities conducted in the area. Each risk is scored using the 0 – 4 rating scale included in the form.

   C. To determine the appropriate score for each identified risk, the reviewer will consider information obtained through a physical tour of the facility, review of at least the past twelve (12) months EOC committee minutes, environmental tours (hazard surveillance) reports, interviews with department heads, and on unit interviews with a representative sampling of staff.

   D. The Chairperson of the EOC Committee in conjunction with the Safety Officer is responsible for identifying an appropriate Risk Assessment Team and scheduling the evaluation of the affected area (s).

   E. The completed risk assessment grids, including the sections on the form for recommended changes in processes, training, personal protective equipment, policies/procedures, and comments will be presented to the EC Committee for review and approval.

F. Should any situation that constitutes an imminent danger be discovered during the course of a risk assessment or at any time, it will be reported immediately to the Safety Officer and the appropriate department manager for appropriate follow-up action to resolve the identified issue(s).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE DISTRICT HOSPITAL
RISK ASSESSMENT

UNIT/AREA	NEEDLES / SHARPS	TB EXPOSURE	CHEMICAL EXPOSURE	ASSAULT	BLOOD / BODY FLUID	LIFTING PATIENT	LIFTING MATERIAL	THEFT	SECURITYINFANT / PEDS	FALLS	ERGO	BURNS	FIRE	GAS VAPOR FUME	ELECTRICAL	ASBESTOS	RADIATION	ELOPEMENT
ACU / ENDO	4	3	3	2	3	2	1	3	1	2	2	1	1	4	2	2	2	1
Administration	1	1	1	2	1	1	1	1	1	1	2	1	1	1	2	2	1	1
Biomed Engineering	2	1	2	1	2	1	1	1	1	1	1	1	1	1	2	2	1	1
Bronchoscopy	3	4	3	1	2	2	1	1	1	1	1	1	1	4	2	2	2	1
Business Office	1	2	1	1	1	1	2	2	1	1	4	1	1	1	2	2	1	1
Cath Lab	4	2	3	1	3	2	1	1	1	2	2	1	1	1	2	2	3	1
Central Processing/Supply	4	2	4	1	4	1	1	1	1	1	2	1	3	4	2	2	1	1
Chemotherapy	4	2	4	1	3	2	1	1	1	3	1	1	1	1	2	2	1	1
CT / MRI	3	2	3	2	2	2	2	1	1	2	2	1	1	1	2	2	2	1
Education	3	2	1	1	1	1	2	1	1	1	3	1	1	1	2	2	1	1
Emergency Dept. Registration	4	3	4	5	2	2	1	1	1	3	2	1	1	1	2	2	2	1
Emergency Dept./ Fast Track	4	3	4	5	4	3	3	3	1	3	2	1	1	1	2	2	3	5
Engineering Dept.	2	1	4	1	2	3	1	3	1	1	2	3	4	3	2	3	1	1
Environmental Services	4	3	4	1	4	1	1	2	1	1	2	1	1	4	2	2	1	1
Evolutions - Physical Therapy	1	1	2	1	2	3	3	2	1	2	2	1	1	1	2	2	1	1

UNIT/AREA	NEEDLES / SHARPS	TB EXPOSURE	CHEMICAL EXPOSURE	ASSAULT	BLOOD / BODY FLUID	LIFTING PATIENT	LIFTING MATERIAL	THEFT	SECURITYINFANT / PEDS	FALLS	ERGO	BURNS	FIRE	GAS VAPOR FUME	ELECTRICAL	ASBESTOS	RADIATION	ELOPEMENT
Family X-ray	2	2	2	1	2	3	3	1	1	2	2	1	1	1	2	2	4	1
Finance Office	1	2	1	1	1	1	3	1	1	2	2	1	1	1	2	2	1	1
Food and Nutritional Services	1	2	2	1	1	1	1	3	1	1	2	4	1	1	2	2	1	1
Home Care	2	3	1	3	3	1	3	2	1	3	3	1	1	1	1	1	1	1
Human Resources	1	1	1	4	1	1	3	1	1	1	2	1	1	1	2	2	1	1
ICU / PICU	4	3	2	5	4	4	3	2	1	3	2	1	1	1	2	2	3	1
Information System (IS)	1	2	1	1	1	1	2	2	1	1	1	1	1	1	2	2	1	1
In-Patient Physical Therapy	2	2	2	1	3	4	2	2	1	3	1	1	1	1	2	2	1	1
Laboratory - Hospital	4	2	3	3	4	2	3	2	1	2	3	1	3	2	3	2	1	1
Materials Management	2	1	4	1	1	1	4	2	1	1	2	1	1	1	2	2	1	1
Medical - 3rd Floor	4	3	2	3	3	4	2	2	1	2	2	1	1	1	2	2	2	3
Medical - 1	4	3	2	3	3	4	2	2	1	3	2	1	1	1	2	2	3	3
Medical - Southwing	4	2	2	2	3	2	2	2	1	3	2	1	1	1	2	2	2	2
Medical Imaging	3	2	3	3	3	3	3	3	1	2	2	1	1	1	2	2	4	1
Medical Records	1	2	1	1	1	1	3	2	1	1	3	1	1	1	2	2	1	1
Medical Staff	4	3	1	1	4	1	1	1	1	1	1	1	1	1	1	2	2	1

UNIT/AREA	NEEDLES / SHARPS	TB EXPOSURE	CHEMICAL EXPOSURE	ASSAULT	BLOOD / BODY FLUID	LIFTING PATIENT	LIFTING MATERIAL	THEFT	SECURITYINFANT / PEDS	FALLS	ERGO	BURNS	FIRE	GAS VAPOR FUME	ELECTRICAL	ASBESTOS	RADIATION	ELOPEMENT
Medical Staff Office	1	1	1	1	1	1	2	2	1	1	2	1	1	1	2	2	1	1
Mineral King Laboratory	2	1	4	2	3	1	3	2	1	1	2	2	3	3	3	2	1	1
Nuclear Imaging	3	2	4	1	3	2	2	2	1	2	2	1	1	1	2	2	2	1
Nursing Administration	3	1	1	1	2	1	2	2	1	1	2	1	1	1	2	2	1	1
OB / Nursery	4	2	3	4	3	3	2	2	3	3	2	1	1	1	2	2	2	2
Operating Room	5	2	3	1	4	3	2	2	1	2	2	2	5	3	2	2	3	1
Outpatient Lab	4	2	1	3	3	2	2	2	1	3	2	1	1	1	2	2	1	1
PACU	3	2	1	1	2	2	2	2	1	3	4	1	1	1	2	2	1	1
Pediatrics	4	2	1	3	3	2	2	2	3	2	2	1	1	1	2	2	2	2
Pharmacy	3	1	4	2	1	1	3	2	1	1	2	1	1	1	2	2	1	1
Pink Ladies Shop	1	1	1	1	1	1	2	2	1	1	1	1	1	1	2	2	1	1
Pre-Admissions	1	2	1	2	2	1	2	2	1	1	3	1	1	1	2	2	1	1
Public Relations	1	1	1	2	1	1	2	2	1	1	2	1	1	1	2	2	1	1
Quality Control / Infection Control	3	3	1	1	3	1	2	2	1	1	1	1	1	1	2	2	1	1
Respiratory Therapy Dept.	3	4	1	2	3	3	2	3	1	1	1	1	1	1	2	2	2	1
Surgery - 2nd Floor	4	2	1	3	3	3	2	2	1	3	2	1	1	1	2	2	4	3
Switchboard (PBX)	1	1	1	1	1	1	2	2	1	1	2	1	1	1	2	2	1	1

Tulare Foundation	1	1	1	1	1	1	3	2	1	1	1	1	1	1	2	2	1	1
Ultrasound	2	2	1	1	2	2	2	2	1	1	2	1	1	1	2	2	1	1
Utilization Review/Pt & Family Svc.	1	2	1	2	1	1	2	2	1	1	2	1	1	1	2	2	1	1

04/05

APPENDIX A

Scoring	Criteria
5	**A high-risk area with possible life threatening or disabling consequences, as well as some history of associated incidents with serious injury.**
4	**A high or significant risk area with possible life threatening or disabling consequences and no history of associated incidents with serious injury.**
3	**A moderate risk of minor injury or inconvenience to patients, visitors, or staff.**
2	**A minimal risk of minor injury or inconvenience to patients, visitors, or staff.**
1	**Virtually no risk of injury or inconvenience to any one.**

Descriptive Name:	Risk Assessment Policy
Descriptive Type:	~~New~~Revised
Document Number:	10-1017.10
Attachments:	Yes (2)
Author:	Julie Gresham
Typist:	~~Julie Gresham~~Andrea Carrasco/Ena Menezes
Creation Date:	2/23/05
Revision Date:	02/01/18
Prev. Dist. Date:	None
Revision Notes:	EOC ~~4/27/05~~ Legal Counsel ~~02/13/06~~ MEC ~~4/12/06~~ General Board ~~04/22/06~~
Effective Date:	~~04/23/06~~
Forward To:	Policy Binders – 5 – Post on Intranet site
Disposition:	**"COLOR"** Copy and Distribution – Administration
Comments:	
Date Completed:	~~04/23/06~~

Policy # 10-1017.10

~~TULARE REGIONAL MEDICAL CENTER~~TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : All Departments

FROM : Administration

SUBJECT: Patient and Family Services

Patient and Family Services is the designated department for Social Services and psychosocial assistance when needed by patient, patient's family and staff.

Director

The Director of Patient and Family Services is an employee of Tulare Regional Medical Center and a licensed clinical social worker. The Director's functions consist of the everyday operation, staffing, management and administrative responsibilities.

Interdepartmental Relations

The relationship between Patient and Family Services Department and other hospital departments will focus on the psychosocial and social services needs of the patient and/or patient's family. Every effort will be made to work in a collaborative manner, maintaining both professional and ethical standards.

Confidentiality

Confidentiality of all information pertaining to patient shall be maintained in strict confidence. Department shall follow hospital policy #15-2071, relating to confidentiality.

Documentation

The Director and staff shall document in patient's chart all social services and/or psychosocial intervention made. Communication that is made between Patient and Family Services staff and physician(s), nurse(s), case manager(s) and other related hospital staff shall be reflected in the patient's chart.

Referral Process

Referrals for social services or psychosocial intervention can be made in the following manner:

Medical Executive Comm.: ~~05/13/09~~

Board of Directors: ~~05/27/09~~

1. Social Service referral Form ~~(see attached).~~

2. Telephone call to Patient and Family Services office.

3. Verbal / Telephone order.

Referrals must be requested by patient, patient's family, physician, primary care nurse, or case manager.

Performance Improvement

Quality of service and care shall be regularly reviewed, evaluated and submitted to the Performance Improvement committee on a quarterly basis. Quality control mechanism will be utilized to study the type(s) of services, or care that are being monitored. This effort will be in conjunction with the Performance Improvement Coordinator.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

~~Tulare Regional Medical Center~~

~~Patient & Family Services~~
~~869 Cherry Street~~
~~Tulare, CA 93274~~
~~(559) 688-0821~~

~~SOCIAL SERVICE ASSISTANCE REFERRAL~~

~~The following agency, or agencies, will provide you with further assistance for your particular situation. Please present yourself at their office, or give them a call at your earliest convenience. They can be reached at the following:~~

~~**NAME & ADDRESS**~~

~~PHONE #~~

Descriptive Name: Patient and Family Services

Descriptive Type: Revised

Document Number: 10-1021

Attachments: Social Service Assistance Referral

Author: Ruben Rojas/Andrea Carrasco/Ena Menezes

Typist: Julie Gresham

Creation Date: 11/09/08

Revision Date: 02/01/18

Prev. Dist. Date: 12/29/05

Committee Review and Approval:	Approval Date:	Comments:
Family Practice	~~03/12/2009~~	
Internal Medicine	~~03/10/2009~~	
MEC	~~05/13/2009~~	
Board of Directors	~~05/27/2009~~	

Effective Date: ~~05/28/09~~

Forward To: Policy Binders – 5 and post to Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: All Employees and Designated Contracted Staff

FROM: Administration

SUBJECT: TRMC Employees' Association

Tulare Regional Medical Center (TRMC) recognizes the social and altruistic needs of TRMC employees and wishes to facilitate and encourage their activities to meet these needs.

The TRMC Employees' Association is established to encourage involvement of TRMC employees in these activities and their active participation in and coordination of these activity functions.

Because certain expenditures are incurred for activities, a TRMC Employees' Association fund structure is set at one dollar ($1) per pay period for all employees electing to participate. With the employee's written permission, the bi-weekly amount may be deducted from their payroll check. Any out-sourced employee who wishes to be a member of the association may pay quarterly dues of $6.00 to the association treasurer. Payment dates are January 1st, April 1st, July 1st and October 1st of each year.

The TRMC Employees' Association organization shall be as follows:

I. An EXECUTIVE COMMITTEE, elected by the Employee Association Members, shall be elected for no more than two (2) successive term.

   A. The Executive Committee shall be elected for a two (2) year term in July. Nominations will take place in May and elections in June.

   B. The Executive Committee shall consist of the following:

      1. President - Shall preside over all association meetings, appoint special committees, encourage and facilitate participation of each Membership committee representative and insure the business of the Association is carried out. (President should have at least two (2) years active experience in the Employees' Association prior to becoming President)

      2. Vice President - Shall assume all the duties and responsibilities of the President in the President's absence or in the event the President is

unable to carry out the term of office. (Vice President should have at least one (1) year active experience in the Employees' Association prior to becoming Vice President.)

3. Past President - Promoting interest in exchanging of experiences that may benefit all Employee Association officers. If there is no past president a co vice will be chosen or elected.

4. Secretary – Two (2) Year Term

   a. Accurately and comprehensively record the minutes of each Membership Committee and Executive Committee meeting.

   b. Distribute the recorded minutes on a timely basis to the Association minute book, the Employee Association Bulletin Board located in the Cafeteria, and to the Administrator.

   c. Post on the Employee Association Bulletin Board and forward to Administration advanced notices of all Membership Committee and Executive Committee meetings at least one (1) week prior to the meeting. All notices shall include the meeting date, time and place.

   d. Record members present at each meeting in the minutes.

5. Co-Secretary – Two (2) Year Term

   a. Shall assume all the duties and responsibilities of the Secretary in the Secretary's absence or in the event the Secretary is unable to carry out the term of office.

6. Treasurer - Two (2) Year Term

   a. Treasurer shall be appointed by the Executive Committee for a one (1) year term. Provide monthly financial statements at committee meetings, be responsible for checkbook balances and financial matters throughout term. Inform the President of quarterly unpaid dues of out-sourced employees. Communicates with President. Signs checks with President.

7. Co-Treasurer – Two (2) Year Term

   a. Shall assume all the duties and responsibilities of the Treasurer in the Treasurer's absence or in the event the Treasurer is unable to carry out the term of office.

8. Public Relations Development – Two (2) Year Term

a. Promoting the true importance of TRMC Employee Association to all employees and to Administration. Promoting events throughout term with flyers, reminders, etc. Be responsible for membership drives throughout the term.

9. Co-Public Relations Development – Two (2) Year Term (1 or 2 co)

a. Shall assume all the duties and responsibilities of the Public Relations Development person in the Public Relations Development person's absence or in the event the Public Relations Development person is unable to carry out the term of office.

10. Ways and Means – Two (2) Year Term

a. Organizing and carrying out a sound fund raising program for the Employee Association. Coordinating the prizes and distribution of prizes of function throughout term.

11. Co-Ways and Means – Two (2) Year Term (1 or 2 co)

a. Shall assume all the duties and responsibilities of the Ways and Means person in their absence or in the event the Ways and Means person is unable to carry out the term of office.

12. Sunshine Person – Two (2) Year Term

a. Responsible for delivery of plants to ill members who are hospitalized, have outpatient surgery, new baby birth to employee member or a spouse, and/or the death of a member of the employee's immediate family. In the absence of the appointed Sunshine Person, a designee will be appointed to carry out the responsibility.

13. Co-Sunshine Person – Two (2) Year Term

a. Shall assume all the duties and responsibilities of the Sunshine Person in their absence or in the event the person is unable to carry out the term of office.

14. Activities Coordinator – Two (2) Year Term

a. Responsible for establishing an overall calendar of events for approval by the Executive Committee and will coordinate the activities for the Christmas Party and Employee Picnic. (Coordinator should have at least 1 year of active experience in the Employees Association prior to becoming Coordinator)

15. Co Activities Coordinator – Two (2) Year Term

a. Shall assist the activities coordinator with all duties and or assume all duties and responsibilities in the absence of the coordinator or in the event the person is unable to carry out the term of office.

16. Ambassador – Two (2) Year Term

a. Two ambassadors shall be elected to the Executive Committee. One (1) ambassador shall be from Evolutions Gym and one (1) ambassador shall be from the clinics. The responsibilities shall be as follows:

I Inform all members in their designated area of all activities that the association is offering.

ii. Sell and turn in all tickets for all fundraisers that the association is offering.

iii. Post all flyers and publications for members in their designated areas.

iv. Inform the President of any questions or concerns from members of their designated areas.

v. Help with membership drive in their designated area.

II. THE AUTHORITY, RESPONSIBILITY AND FUNCTION OF THE EXECUTIVE COMMITTEE SHALL BE AS FOLLOWS:

A. Executive Committee:

1. Administer the continuing recurring activities as established.

2. Disburse money to meet Association financial obligations.

3. Coordinate the operation of special committees.

4. Insure that a complete and accurate accounting is made each month to the membership:

a. Financial standing

b. Minutes

c. All activities just completed, upcoming, and planned for the future and the projected revenue and expenditures of each.

d. General status of the Association membership.

e. In the event that a position should be vacated before the next election, the executive committee will appoint a person to fill the position without holding an election.

III. ESTABLISHED CONTINUING RECURRING ACTIVITIES:

A. The following activities are established by the Association as continuing and recurring:

1. Leaving employment of TRMC Association Members - An employee who has been an Employee Association member for at least ten (10) years and is leaving the employment of the hospital shall be given a twenty-five dollar ($25.00) gift by the Association. An employee who has been an Employee Association member for twenty (20) or more years and is leaving the employment of the hospital shall be given a fifty dollar ($50.00) gift by the Association. Any Employee Association member shall notify the President as soon as possible for authorization of the expenditure. The President shall make the presentation.

2. Hospitalized Association Members - An employee member of the association who is hospitalized (inpatient or outpatient surgery) shall be sent a plant or flower arrangement having a maximum expenditure of twenty-five dollars ($25.00). (First time $25.00 plant, card each time thereafter within one (1) year period.) The individual departments are responsible for notifying the Sunshine Chair. The Sunshine Chair shall be given notice within 60 days.

3. A Death in the Association Member's Immediate Family - (Brother, sister, spouse, child, mother or father, mother-in-law or father-in-law, grandparents, including step-family members), or the Association member - flowers or plant shall be sent to the employee or family with a card expressing the Association's sympathy. The individual departments are responsible for notifying the Sunshine Chair.

4. Picnic - The Association sponsors an annual picnic, upon availability of funds. The Association shall supply the main dish, beverage, place settings, games and prizes. Tickets shall be distributed for this activity and a charge shall be made dependent on the cost and location for all attending.

5. Christmas Party - The Association sponsors a Christmas party dinner and dance, upon availability of funds.

a. Employees, their spouse, family members and/or friends, Doctor’s office staff, volunteers, and contracted staff are invited to attend.

b. The Association shall supply the dinner, place settings, entertainment, games, gifts, and door prizes.

c. Tickets shall be distributed for this activity. Tickets shall be free to Association members who have been a member for at least six months / or is a new employee and signed up within 90 days of new hire date. A charge shall be made for non-association member employees and all guests in order to defray the expenses.

d. Tickets shall be distributed. The President shall coordinate the distribution.

e. Tickets distributed to employee association members and retired employee association members, are for their sole use only and may not be sold or given to others.

f. Guest tickets shall be priced in accordance to the cost of the function. No refunds shall be made.

g. No tickets shall be sold at the door, and final ticket sales shall be closed in a timely manner for caterer arrangements.

h. Dress code shall be semi-formal to formal.

6. Monthly Drawing - A monthly drawing in the amount of $25.00 will be held. Ways & Means will choose where the gift certificate will be purchased. Those eligible: Employee Association Members only. Members will be eligible to win once per year only. New employees (Association members) will be added to the list monthly.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: TRMC Employees' Association

Descriptive Type: ~~Revised~~ Delete Policy

Document Number: 10-1025

Attachments: None

Author: Robert M. Hernandez

Typist: ~~Julie Gresham~~ Ena Menezes/Andrea Carrasco

Creation Date: 09/01/09

Previous Dist. Date: 10/27/05

Committee Review:	Approval Date:	Comments:
Board of Directors	09/23/09	

Effective Date: 09/23/09

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba Tulare Regional Medical Center

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Expense Consideration and Reimbursement for Workshop, Seminars, Conferences, Meetings and other Hospital Business Related Functions

Requests for Hospital funded attendance at instructive seminars, conferences, workshops, college courses or other hospital business related functions will be evaluated and approved or disapproved using the following criteria:

(1) Appropriateness to the person's representative interests (departmental and professional).

(2) Expected upgrade in attendees' knowledge, skills, understanding and capabilities applicable to their TLHD job performance improvement.

(3) Budgetary consideration. Balance on their departmental seminar budget.

(4) Employee's previous attendance of similar meetings.

(5) Out of town meetings must be pre-approved by the department manager.

Approval to attend such meetings does at all times require the attendee to share the information learned from the meeting with others in their department or when appropriate with the hospital as a whole. Continuing upgrade of staff knowledge and skill is considered important toward delivery of "State of the Art" patient care and Hospital business acumen. To accomplish this continuum, Tulare Local Health Care District recognizes attendance to important meetings are necessary and desirable. However, limitations of budget, time and staffing of necessity place some limitations. Therefore, requests for such meetings; shall be analyzed to insure hospital funds are best spent for the good of the entire system.

Employees desiring to attend a meeting or seminar, etc., shall first review the matter with their department head to establish the level of the meeting's importance. With the manager's approval, the appropriate request and registration forms shall be completed and sent to Finance for payment. A sample copy of the Conference Travel Expense Account form is attached.

Effective Date: ~~02/28/08~~

Approved:

Board of Directors: ~~02/27/08~~

(10) Administration General:
Expense Consideration and Reimbursement for Workshop, Seminars, Conferences, Meetings and other Hospital Business Related Functions 10-1031.1

Employees returning from such meetings must complete the appropriate reimbursement form (included) and give it to their Department Manager. Reimbursement forms shall be forwarded to the Finance Department for payment. Receipts should be attached to the request for reimbursement form. When a receipt is not available an explanation for itemized expenses will be necessary for reimbursement.

Transportation Reimbursement

Tulare Local Health Care District may reimburse for transportation expenses when traveling on official and authorized business for and on behalf of the hospital. Receipts must be attached to the hospital expense form to facilitate reimbursement. The most reasonable and cost effective means of transportation shall be used unless otherwise pre-authorized. When other than the most cost effective means of transportation is used, and the other means is the employee's own choice for personal benefit and reasons, reimbursement shall be made based on the most reasonable means or employee's choice of transportation, which ever is the lesser cost, unless the most reasonable means is not available and has been so documented.

Transportation Expenses

Mileage:

Mileage payments for use of personal vehicle shall be made at the current business mileage rate as determined by the IRS. Mileage payments are intended to reimburse the employee for fuel, maintenance, depreciation, insurance premiums and repairs.

Airline tickets shall be paid/reimbursed at coach rates. Airline travel claims for a higher fare or extra charge by airline may be allowed if accompanied by a full explanation stating the facts constituting the official necessity.

A paid receipt or a flight coupon must be attached to the travel expense claim form to obtain reimbursement.

Commercial Automobile Rental

Employees shall be reimbursed for actual and necessary costs of car rental when approved in advance. Costs shall be substantiated by a receipt. A full explanation shall accompany the travel expense claim when it is necessary to pay an extra charge or premium rental rate for convertible body style, sun roof or other luxury items.

Selection of a full-size class automobile will be recognized as reasonable transportation.

Employees must purchase collision damage waiver when renting an automobile, the cost of which shall be reimbursed. Failure to do so will cause employee to be liable for any damages.

Other Commercial Transportation

The actual cost for bus and train fares shall be reimbursable to employees. Taxi fare may be reimbursable when properly justified. Receipts must be attached to travel expense claim to obtain reimbursement.

Meal Charges

When traveling on official and authorized business for TLHD employee meals shall be reimbursed in accordance with the following:

Reimbursement for meals shall not exceed a total of $40.00 per day including tips and taxes for each twenty-four (24) hour period.

When less than a full twenty-four (24) hour period, meal charges are not reimbursed.

Receipts including the meal(s) date(s) must be attached to the travel and expense claim form (see attachment). Expenses in excess of $40.00 will not be reimbursed.

Lodging

Employees shall be reimbursed for lodging when traveling on official and authorized business for TLHD. The inclusive date of each trip for which expenses are claimed for lodging shall include the time(s) of departure and return documented on the travel expense claim. Time of departure and return as used herein, means the time the employee starts from and returns to the hospital or home, whichever is the location of departure and/or return from the official and authorized trip.

Cost of lodging is not to exceed $150.00 per day without prior approval from the division chief.

Miscellaneous Expenses

Employees shall be reimbursed for actual costs of miscellaneous expenses when traveling on official and authorized business for TLHD. Miscellaneous expenses may be telephone calls and telegrams, parking fees, tips for bellmen and porters and other charges necessary and reasonable to complete travel.

A receipt or signed statement noting date of transaction, purpose of expenditure, description of expenses, and the amount must be attached to the travel expense claim to obtain reimbursement.

Advances may be issued for travel expenses. Receipts must be turned in within ten (10) working days after return from trip with manager's approval to receive reimbursement from the hospital.

Payment for reimbursement will be made within the next appropriate Accounts Payable cycle. Check requests will be processed in a timely manner.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba Tulare Regional Medical Center

POLICY/GUIDELINE MANUAL

TULARE LOCAL HEALTH CARE DISTRICT
Seminar/Conference Travel - Expense Account

Name:	Dept. #	Sub.Acct. # **87**
Nature of Expense:		
Title of Seminar/Conference:		
Location of Seminar:		
Arrival Date:	Departure Date:	
Dates – From:	To:	
Is this seminar scheduled on your workday(s)?	☐ Yes	☐ No
Deadline for cost savings on registration:_	Date:	
	Registration Fee	$
Amount of refund policy for registration cancellation		**$**
Mileage -Total Miles: _____		$
Transportation: Air, Bus, Train, Taxi, Care Rental (Attach receipt)		**$**
Lodging: Per night $_____ Total number of nights _____		
Meals: Maximum allowance for meals in 24 hour period is $40.00. (Meal charges are not reimbursed when less than a full twenty-four (24) hour period)		$
Other Expenses:		$
		$
	TOTAL EXPENSES	$
Signature of Individual:	Remaining Balance	$
Signature of Dept. Head (Required)	This Request	$
Signature of Division Chief (Required)	New Remaining Balance	$

ISSUE CHECK PAYABLE TO	CHG DEPT #	DOLLAR AMOUNT	CK # and DATE	DATE MAILED
1.				
2.				
3.				
4.				

ITEMIZATION OF REIMBURSEMENT REQUEST

Itemized documentation for meals and miscellaneous expenses incurred while on TLHCD business:

ISSUE CHECK TO: _____ DATE: _____

EMPLOYEE NAME: ACCOUNT:

CHARGE DEPARTMENT: SUB ACCOUNT:

TOTAL REQUESTED	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
DATE							
HOTEL							
CAR RENTAL							
AIR FARE							
MEALS							
GASOLINE OR MILEAGE Reimbursement Total Miles:_____							
PARKING							
OTHERS – SPECIFY							
TOTAL							

Explanation of miscellaneous expenses _____

Reason(if applicable) of variance from PO _____

Please include original receipts for hotel bills, air fare, coupons and any charge receipts as stated on Hospital policy.

If receipts are not available, attach an itemized explanation for each expense.

_____ _____
EMPLOYEE SIGNATURE **DATE**

_____ _____
DEPARTMENT MANAGER SIGNATURE **DATE**

Descriptive Name:	Expense Consideration and Reimbursement for Workshop, Seminars, Conferences, Meetings and other Hospital Business Related Functions
Descriptive Type:	Revised
Document Number:	10-1031.1
Attachments:	Yes – Itemization of Reimbursement Request Seminar/Conference Travel – Expense Account
Author:	~~Delbert Bryant~~
Typist:	~~Julie Gresham~~Carol Bradford
Creation Date:	02/18/08
Revision Date:	02/01/18
Prev. Dist. Date:	11/30/06

Committee Review:	Approval Date:	Comments:
Board of Directors	~~02/27/08~~	

Effective Date:	~~02/28/08~~
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Policy combined with #10-1031 Expense Consideration for Workshops, Seminars, Conferences, Meetings, etc. and renamed.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Hospital Governing Board and All TDHS Employees

FROM: Administration

SUBJECT: Expense Reimbursement Disclosure

Assembly Bill No. 1542 Section 53065.5of the State of California established new rules regarding disclosure of expense reimbursements for all employees and members of the governing board of Special Districts effective 1/1/95.

The District is required to annually make available for public inspection, any reimbursement paid by the District to any employee or member of the governing body during the fiscal year of $100.00 or more for each "individual charge" for services or products. One individual charge includes one meal for one person, one day of lodging, registration fee for a class or seminar, transportation expense (mileage, airfare, auto rental, etc.), education materials (books and supplies) and other like services or product purchases.

The District will make available annually required information for public inspection.

The information will be prepared from the accounts payable system which records amounts paid and can be substantiated by reimbursement forms or education and travel expenses request forms.

All requests for products or services for individuals or groups of individuals must include the amount per item, per person, per day or incident.

The required disclosure cannot be avoided by making payments directly to hotels, organizations or restaurants providing services. Conference expenses must be separated to the extent that costs exceed(ed) $100.00 for any single item such as lodging or registration fees.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH ~~-~~CARE DISTRICT
~~(Tulare District HealthCare System) (TDHS)~~dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Approved:

Board of Directors: ~~10/25/06~~

Expense Reimbursement Disclosure
10-1031.2

Descriptive Name:	Expense Reimbursement Disclosure
Descriptive Type:	Revised
Document Number:	10-1031.2
Attachments:	None
Author:	~~Delbert Bryant~~
Typist:	~~Julie Gresham~~Carol Bradford
Creation Date:	3/06/02
Revision Date:	02/01/18
Prev. Dist. Date:	3/28/02

Committee Review:	Approval Date:	Comments:
Board of Directors	~~10/25/06~~	

Effective Date:	~~10/26/06~~
Forward To	Policy Binders – (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Theft or Suspected Theft of Property

In an effort to minimize or control theft in the hospital, all theft or suspected theft of patient, visitor, employee or hospital property shall be reported, on a timely basis, to the Tulare Police Department. The only exception will be those instances where drugs or drug items are involved, which will be coordinated through the Director of the Pharmacy.

The following procedure is established:

1. Security shall be notified immediately when the loss is determined.

2. The Security Officer shall be responsible for the completion of the Security incident report specifically noting all persons involved or having knowledge of the incident.

3. Security will notify the police department to respond and conduct an on-sight interview/investigation with all persons related to the loss unless the reporting party does not wish to make a policy report.

4. If reported to the police, the case number shall be obtained from the Police Officer and documented on the Security Officers incident report, and forwarded to their Supervisor. The Security Supervisor will complete the hospital Quality Review Report (QRR) and forward to the Risk Manager.

5. All follow-up information shall be coordinated with the police department if indicated, such as parties involved in the immediate area, notification if the item is subsequently found, or any other factors pertinent to the situation.

6. Tulare Regional Medical Center shall not be responsible for damage or theft of personal property of visitors or employees, contracted staff or physicians.

   In the case of theft or suspected theft of patient's property, refer to policy 10-1117 Securing Patient Monies/Valuables and Property Damage or Loss.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Theft or Suspected Theft of Property

Descriptive Type: Revised

Document Number: 10-1033

Attachments: None

Author: Lionel Machado/~~Andrea Carrasco/Ena Menezes~~

Typist: Melissa Arend/Andrea Carrasco/Ena Menezes

Creation Date: 10/21/06

Revision Date: ~~08/21/14~~ 02/01/18

Prev. Dist. Date: 07/28/11

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~08/21/14~~	
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT ~~HOSPITAL~~
dba Tulare Regional Medical Center

POLICY/GUIDELINE ~~MANUAL~~

TO: All Facility Personnel and Medical Staff

FROM: Administration

SUBJECT: Mandated Reporting Requirements

PUPROSE:
Facility personnel and medical staff are responsible for identification of events that may require mandated reporting. It is the responsibility of the individual who identified the event or the department manager~~'s~~, or division chief to report to the proper authorities. This policy is designed to help the individual, department manager or others who need to identify any mandated occurrence to others outside of the facility.

REPORTING REQUIREMENTS GRID:
The following grid outlines those known events or occurrences that require mandated reporting to agencies outside of the facility. Depending on the type of event an electronic ~~Quality Review Report (QRR)~~ report will ~~need to~~ be completed~~made out~~ as well. See the policy on Quality Review Reporting #10-1035 that describes incidents that require an Electronic ~~Quality Review~~ Report (QRR) ~~(QRR)~~.

The grid outlines (see attached grid):

- the circumstance requiring the mandated reporting
- which applicable law, regulation, or statute requiring the reporting
- whom to report to
- who ~~is to do the~~ report~~sing~~
- if the event requires an Electronic ~~Quality Review~~ Report ~~to be~~ (QRR) sent to Risk Management
- when and how to report (by phone, written report, specific form).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~1/26/06~~

Approved:

Medical Executive Comm.: N/A

Board of Directors: ~~1/25/06~~

(10) Administration
General:
Mandated Reporting Requirements
10-1035.1

TULARE LOCAL HEALTH CARE DISTRICT ~~HOSPITAL~~
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE ~~MANUAL~~

MANDATED REPORTING REQUIREMENTS GRID

CIRCUMSTANCE	REGULATION STATUTE OR LAW	BY WHOM	TO WHOM	WHEN/HOW
Animal Bites	County Requirement	Emergency Dept.	External: Humane Society	Phone Call, and Send Animal Bite Report
Assault & Battery to On-duty Health Care Personnel **	A.B. #508 CA Penal Code # 240,242	Security Department, Department Manager, Risk Manager	Internal: Risk Mgmt External: Local Law Enforcement	Phone Call within 72 hours of offense and written report within 72 hours
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, 920	Emergency Dept, Social Services Dept, Nursing Staff	External: Local Law Enforcement	Phone police immediately, ~~and~~ written report – two (2) working days. Forms in ED: & Nursing Units
Cancer/Reportable Neoplasms	Title 17, CA Code of Regulations, Section 2593	Through Disease (Medical Records Dept) by the Central Calif. Cancer Registry	External: California Dept. of Health Services Cancer Prevention Section	Within six (6) months of diagnosis
Certification of Birth	Health & Safety Code Section 10101	Birth Certificate Clerk ~~Medical Records Department~~Health Information Management (HIM)	External: ~~Hillman Health Center~~County	Within ten (10) days of birth
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service~~s Department~~ Health Practitioners Nursing Staff	External: Child Protective Services or Local Law Enforcement	Immediately by Phone, written report ~~and W~~within 36 hours ~~in Writing~~
Chromosomal Defects in Fetus or Infant	Title 17 - CCR 6532	Lab performing the analysis or physician making diagnosis	External: DHS	Health Information Management (HIM)~~Ask Medical Records~~ within 30 days of diagnosis using form provided by DHS
(Illegal) Drug Use - non employee **	CA Penal Code, Section 11-160	Security Department	External: TPD	Telephone and written report
(Suspected) Elder & Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code # 15600—15637	Social Service~~s Department All~~ Health Practitioners Nursing Staff	External: Local Law Enforcement and/or Adult Protective Services	Telephone Report ~~-~~Immediately, Written Report- Within two (2) Working Days
Infectious Diseases (Reportable*)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory-Microbiology & Chemistry	External: Infection Control Practitioner Public Health Department receives CMR FAX. After Faxing send report to ICN	FAX information to Public Health using California Morbidity Report
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Emergency Department staff and/or physician	External: Public Health Department Local Health Officer who reports to DMV	FAX information to Public Health using California Morbidity Report

** Electronic Report (Q~~uality~~ R~~eview~~ R~~eport~~) to Risk Management

CIRCUMSTANCE	REGULATION STATUTE OR LAW	BY WHOM	TO WHOM	WHEN/HOW
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Emergency Department Social Services	External: DHS Tulare County Mental Health for 5150 Hold	Phone after 24 hour mark followed by letter to DHS
Missing Patient **		Risk Management Division Administration Security Department	External: Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)
Needle stick Injury/BS Exposure	OSHA Rec. - Blood borne Path.	Employee reports to Supervisor. Employee goes to Emergency ftor ~~have~~ exposure assessment	Internal: Emergency Dept staff reports incident to Infection Control	All follow-up paper work is reported to ICN
Neural Tube Defects in a Fetus	Title 17, CA Code of Regulations, Section 6531	~~Medical Records Department~~HIM runs birth Defect Index	External: California Dept. of Health Services Alpha-Foto Protein Screening Program	Within 30 days of initial diagnosis
Newborn Screening Test refusal (PKU)		Maternal Child Health Unit Representative – Nursing Staff	External: California Department of Health Services Genetic Disease Branch	Prior to infant discharge complete~~Fill out~~ form
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S-14003	Physician	External: Employer & Employee's Insurer	Written Report within five (5) working days
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Infection Control Practitioner	External: Local Health Officer	FAX information to Public Health using CMR. Phone as indicated
Patient Deaths	Title 22 -- 72549 - HSC 10250 HCFA Dept HHS 42 CFR Part 482 AB 631 Section 7184 Public Law 99509 Section 9318	Health Care Practitioner~~;~~ Physician Nursing Staff	External: Coroner (if meets criteria) DHS at a time and manner as requested, Pt. Reps – TCMC ~~Organ Procurement (OPO)~~Donor Network West	Phone within 1 hour~~immediately~~ Complete form 8720-37 Policy #127-12028 Call (800) 553-6667
Patient death due to unusual circumstances, i.e. suicide **	Title 22 Section 70737, 71535	Health Care Practitioner Administration	External: Local Law Enforcement officer, Medical Examiner and DHS	Local law enforcement contacted prior to medical examiner. DHS within 24 hours by phone confirmed in writing. Electronic report~~Quality Review Report~~ on file by facility for one (1) year **
Patient Injury/Death, due to faulty equipment **	Safe Medical Device Act	Health Practitioner Supervisor Patient Care Review Department	External: Medical Device & Lab product Problem reporting Program – FDA	Within 24 hours via form and phone 800 638-6725

** Electronic ~~Quality Review~~ Report (QRR) to Risk Management

CIRCUMSTANCE	REGULATION STATUTE OR LAW	BY WHOM	TO WHOM	WHEN/HOW
Patient Transfer Violation	(COBRA) Health & Safety Code 1317 through 1317. 99 Title 42 U.S.C. Section 139 dd	~~Sr. Assoc. Admin of Clinical Services~~CNO or Administrator on call	Internal: ~~Sr. Assoc. Admin of Clinical Services~~CNO External: DHS and HCFA per Administrative decision	Within three (3) days
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Nursing Staff	Internal: Emergency Dept. Mgr External: ~~Local~~Public Health ~~Officer~~ Co. Dept. of Agriculture Deputy Agriculture Commission	Phone call within 24 hours
PKU Specimen not obtained		Nursing Staff	External: Receiving facility California Department of Health Services Genetic Disease Branch	When patient transferred
Rhesus Hemolytic (RH) Disease - Newborn	Title 17, CCR Section 6510, Title 22 CCR 70737	Physicians	External: DHS – Maternal Child & Health Office physician who made diagnosis	
Reye Syndrome	HSC Section 304.5	Attending Physician	External: DHS	Within seven (7) days of diagnosis using reporting ~~form~~ "form "CBC Reye Syndrome…"
Threat to kill	Tarasoff *	Psycho Therapist/Health Care Practitioner	External: Intended victim and local law enforcement	Immediately by telephone
Unusual occurrences that threaten the welfare of the patient, staff or visitors **	Title 22 Section 70737, 71535	Nursing Staff, All others	External: Local Health Officer and DHS***	24 hours by telephone – confirmed in writing. ~~Electronic Quality Review~~ Report on file by facility for one (1) year **

** Electronic~~Quality Review~~ Report (QRR) to Risk Management

* Responsibility of county health offices to notify pre-hospital emergency medical care personnel. No release of information provided to hospitals to do this – confidentiality of patient to be protected.

*** Definition: An unanticipated outcome is defined as an adverse outcome or injury that is caused by medical management rather than the underlying condition of the patient. – **NOTIFY: Staff shall notify~~ied~~ the Nursing Supervisor of the occurrence as soon as possible. The Nursing Supervisor will notify DHS by phone or fax within 24 hours of the event.**

Descriptive Name: Mandated Reporting Requirements

Descriptive Type: Revised 12/20/17

Document Number: 10-1035.1

Attachments: Included

Author: ~~Julie Gresham~~ Quality

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 8/04/05

Revision Date: 2/1/18

Prev. Dist. Date: 12/31/02

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee		
Legal Counsel	N/A	
MEC	N/A	
General Board		

Effective Date: ~~11/20/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments: Bypassed legal counsel and MEC due to immediate corrective action for DHS

Date Completed: ~~1/26/06~~

TULARE LOCAL HEALTH CARE DISTRICT ~~HOSPITAL~~
dba Tulare Regional Medical Center

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Clinical Staff, and all Departments

FROM: Administration

SUBJECT: Disclosure of Unanticipated Outcome Information

Policy Statement: The responsible licensed independent practitioner or his or her designee informs the patient of the outcome of any care, treatments or services provided to the patient and, when appropriate, the family, including anticipated outcomes (TJC~~AHO~~ intent of standard RI.2.90/DNV).

Definition: An unanticipated outcome is defined as an adverse outcome or injury that is caused by medical management rather than the underlying condition of the patient. This adverse outcome or injury results in a significant alteration of function (anticipated for a duration of two weeks or more), and/or results in permanent injury or death.

For related definitions, refer to policy 10-1017.7, "Patient Safety Program".

Disclosure:
Refer to policy 10-1017.7, "Patient Safety Program regarding the hospital's Non-Threatening/Non-Punitive Reporting Policy.

At a minimum, the patient and when appropriate, his or her family, is informed about the following:

1. Outcomes of care, treatment, and services that have been provided that the patient (or family) must be knowledgeable about to participate in current and future decisions affecting the patient's care, treatment, and services.

2. Unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by the Joint Commission, refer to Policy #10-1035.2 Sentinel Event Investigation.

3. Disclosure to the patient (and family if appropriate) should take place as soon as reasonably possible (within 24 hours) after verification that an unanticipated outcome has occurred.

Effective Date: ~~1/26/06~~

Approved:

Medical Executive Comm.: N/A

Board of Directors: ~~1/25/06~~

(10) Administration
General:
Disclosure of Unanticipated Outcome Information
10-1035.3

4. When an unanticipated outcome is identified, the patient's physician will consult with other professionals as appropriate to determine the facts involved in the case and to develop a plan of action regarding care of the patient and disclosure of appropriate facts to the patient (i.e. assess, plan, implement and, later, evaluate).

5. Disclosure is the responsibility of, and under the direction of, the patient's physician. The physician may choose to inform the patient individually or as part of a team of professionals. The physician may delegate disclosure to another professional (or team) when he/she determines that course of action would be more appropriate.

6. It is recommended that whomever provides the disclosure be empathetic and make every effort to view the event from the patient's perspective.

7. After disclosure, the patient's (and family's if appropriate) response is evaluated.

8. Staff shall notify the Nursing Supervisor as soon as possible, of any unanticipated occurrence that causes an adverse outcome or injury to a patient. The Nursing Supervisor shall phone or fax notification to DHS within 24 hours.

DOCUMENTATION:

1. A Quality Review Report (QRR) will be generated.
2. A Root Cause Analysis will be performed when appropriate.
3. Appropriate facts will be recorded in the patient record including a description of the event, the disclosure (and by whom), and the patient's response.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Disclosure of Unanticipated Outcome Information

Descriptive Type: Revised

Document Number: 10-1035.3

Attachments: None

Author: Julie Gresham/Andrea Carrasco/Ena Menezes

Typist: Julie Gresham

Creation Date: 8/04/05

Revision Date: 02/01/18

Prev. Dist. Date: 8/29/05

Committee Review:	Approval Date:	Comments:
Patient Safety Committee	~~12/28/05~~	
Legal Counsel	N/A	
MEC	N/A	
Board of Directors	~~1/25/06~~	

Effective Date: ~~1/26/06~~

Forward To: Policy Binders – (PBX and Administration) and Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments: Bypass Legal Counsel and MEC due to immediate corrective action for DHS

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Active Medical Staff and All Employees

FROM: Administration

SUBJECT: Interpreter – Non-English and Limited English Proficient (LEP) Patients

The DISTRICT recognizes that individuals must be able to communicate effectively with their healthcare providers.

When language barriers exist between providers and patients, the quality of information is diminished and the outcome of the patient encounter may be unsatisfactory. This may lead to decreased patient compliance and increased potential for medical errors and misdiagnosis.

Assembly Bill (AB) 389 (chapter 327, statutes of 2015) require health care facilities (hospitals) to make its language assistance policy publically available to its service area.

I. PURPOSE

1. The purpose of this policy is to detail the communication system that is used for patients who have Limited English Proficiency (LEP). Such a system will include language interpretation services to ensure effective communication between patients and staff during critical health services or treatment situations.

2. To provide guidelines for coordinating a timely response to meeting the assessed special language needs of individual patients, their designated representative, guardian, or next of kin.

3. To comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 and Health and Safety Code of California.

4. California Health & Safety Code Sec 11135, et seq and its regulations 22 Cal Code Regs 22 98000 et seq require that there be in place an “alternative communication system which ensures free and equal access to all services of the hospital district (Daniel, 2008)

5. Title VI of the Civil Rights Act of 1964 requires federal fund recipients to ensure the eligible Limited English Proficiency (LEP) persons have "meaningful access" to health services.

6. Joint Commission and DNV recommendations are to provide culturally and linguistically appropriate services (CLAS).

II. POLICY

1. In emergency situations, treatment will be provided in accordance with standard medical practice. Interpreters will be sought promptly, but treatment will not be delayed pending the arrival of an interpreter.

2. It is the policy of the DISTRICT to provide equal access to and equal participation in healthcare activities for persons with LEP (limited English proficiency). The DISTRICT provides communication aids and services at no cost to the patient during their course of care. It is the policy of the DISTRICT to use competent medical interpreters during critical health services or treatment situations.

3. Competent Interpreters:

   A. The DISTRICT's use of bilingual staff members to deliver medical and/or treatment information is discouraged unless interpreters have been deemed competent in critical medical information through competency evaluation.

   B. Competent interpreters will be provided education sessions to assure medical terminology currency and other issues related to interpretation.

4. Critical Medical Information:

   A. Interpreters shall be used in any situation where clear and effective communication is necessary. Situations in which the presence of an interpreter for limited English speaking patients is necessary to ensure thorough and accurate communication include, but are not limited to:

      1. Explaining a medical procedure or intervention(s).

      2. When Informed Consent is required for treatment.

      3. When explaining and describing medical conditions, tests, treatment options, medications, surgery, and other procedures.

      4. When providing a diagnosis, prognosis, and recommendation for treatment during treatment and testing procedures.

      5. When providing instructions for medications, post-treatment activities, and follow-up treatments.

      6. When providing mental health/drug and alcohol services or counseling for patients and family members; including group or individual therapy.

7. Providing information about blood or organ donations.

8. Discussing complex billing or insurance matters.

9. When obtaining an Advance Directive.

10. History and Physicals, Assessments (neuro, pain management, symptomology, change in condition).

11. Evaluations and Consultations

12. Discharge Planning and Self-Treatment Instructions

B. Non-critical Medical Information: Quick informal conversations that can be managed with limited skills (i.e., use of language tools-picture cards, basic language), such as requests to go to the bathroom, etc. are generally considered to be non-critical and any bilingual individual can assist.

C. Interpreter Services are to be available 24 hours a day, 7 days a week, and free of charge to the patient.

D. All employees shall be instructed about interpretation services and resources available during their orientation program and on an ongoing basis as appropriate.

E. The patient's primary/preferred language is to be identified and noted in the patient's medical record and plan of care.

F. Limited English Proficiency (LEP), non-English speaking patients shall be offered an interpreter at the point of service or at any point requested during the provision of service.

G. A patient is not required or expected to use friends or family members as interpreters because the use of such individuals may result in breach of confidentiality and reluctance from the patient to reveal personal information critical to the services to be provided. A friend or a family member may be used only if requested or authorized by the patient by signing the waiver (see attached waiver form-*Appendix A/B*). The use of friends or family members as interpreters is to be documented in the patient's medical record along with the signed waiver.

H. Patient/families are to be made aware of the bilingual resources available in the following ways:

1. Signage/postings

2. Multi-lingual notices are to be placed in conspicuous locations informing patients of available bilingual services and how to access them.

3. Notices shall be posted in the emergency room and major entrances, admitting areas and lobbies.

4. Patients requiring information in their primary/preferred language received both verbal and written notices informing them of their right to receive language assess services.

I. Written translation of forms and patient information.

1. The Forms Committee (or designee) will approve all patient information materials prior to being sent out for translation.

2. Only District approved agencies may be used to provide translation of patient information.

III. PROCEDURE

1. IDENTIFICATION OF PATIENTS WHO REQUIRE INTERPRETER SERVICES

A. Whenever staff registers a patient or schedules an appointment for a patient who has LEP, staff will identify the patient's primary/preferred means of communication. This can be accomplished in several ways:

1. Assess the patient regarding what language she/he speaks.

a. By using a Language Identification Card or poster.

b. Or by calling Language Line Services.

B. Staff shall record whether a patient needs interpreter services and the language s/he speaks in computer information system.

1. For all patients who have LEP, staff shall enter on face sheet (i.e., Spanish/interpreter,) in the “primary language field.”

C. Whenever possible, have the patient sign all admission consent forms and waiver documents in their primary language.

D. In the patient care areas the communication barrier will be identified on the plan of care.

2. REQUESTING AN INTERPRETER

A. All patients who have been identified as needing an interpreter should have an interpreter available. Staff must contact the appropriate competent interpreter for the patient to explain all critical medical information such as tests/procedures, surgery, to obtain informed consent, and to give critical instructions.

B. Type of interpreting services:

1. Language Line Service

a. Provision of interpreter service to all non-English speaking patients shall be provided via the Language Line. Staff is encouraged to use the Language Line Services for the following situations:

i. An emergent need when there is not an interpreter immediately physically available.

ii. A competent Healthcare Interpreter is required and not immediately available.

iii. An interpreter is not available for the specific language requiring interpretation.

iv. The service is available 24 hours per day, seven (7) days per week. Dual headset speakerphones are available throughout the hospital for this purpose. Department Directors and the Nursing Supervisor are available to assist patients, physicians, and staff access to this service.

b. The Language Line phone number is **(800) 523-1786.**
c. Provide: Client ID **201200.**
d. Indicate: Language
e. Provide: Department Number

3. DOCUMENTATION OF USE OF INTERPRETER

A. Staff is to document the following information in the patient's medical record with each interpreter encounter.

1. Interpreter used (first and last name), interpreter ID #, and language spoken.

2. Date and time.

3. Length of interpretation.

IV. DEFINITION OF TERMS

1. **Non-English or Limited English Proficiency (LEP)** - those individuals whose native language is other than English and who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with healthcare providers.

2. **Communication Barrier** - applies to a person who is intubated, has neurological deficits or speaks another language hindering communication.

3. **Qualified Sign Language (ASL - American Sign Language) Interpreter**: A person who is fluent in sign language and is trained and proficient in the skill and ethics of interpreting and who is knowledgeable about the specialized terms and concepts that need to be interpreted for purposes of ensuring effective communication.

4. **Competent Healthcare Interpreter**: A specially trained professional who is fluent in both English and another language, who is trained and proficient in the skill and ethics of interpreting, and who is knowledgeable about the specialized healthcare terms and concepts that need to be interpreted for purposes of ensuring effective communication. Such an individual passed an exam by a competent educator.

5. **Interpreter:** A person who is fluent in English and in the necessary second language and who can speak, read, and readily interpret the necessary second language.

   Note: Competent interpreters must have the ability to translate the names of body parts and to competently describe symptoms and injuries in both languages. ""Bilingual staff may provide patient instructions only if they had their competency established to do so (some examples are RN, LVN, Admitting, Registration, and clerical staff) (Daniel, 2008).

6. **Translator**: Same as interpreter but as related to the translation of written information. Renders the text in one language into equivalent text in another language.

7. **Language Line**: Language line service available 24 hours a day, 7 days a week.

8. **Patient's Designated Representative**: The person authorized by law or hospital policy to act on behalf of a patient who lacks decision-making capacity.

9. **Contracted Services**: A designated service that provides 24-hour foreign language interpretation services via telephone (Language ~~Service~~ Line) through which the DISTRICT has contractual agreements that define expectations and response time.

V. REVIEW:

1. This policy is to be reviewed and revised periodically.

VI. ATTACHMENTS:

Appendix A: Waiver of Interpreter Services

Appendix B: Spanish Waiver of Interpreter Services

Appendix C: Guidelines for the Use of Interpreters

Appendix D: Interpreter Reference

VII. References:

1. Americans with Disabilities Act (ADA).

2. Title VI of the Civil Rights Act of 1964.

3. Health and Safety Code of California.

4. Comprehensive Accreditation Manual for Hospitals.

5. Fresno Community Hospital Interpreter Guidelines.

6. California Health & Safety Code Sec 11135, et seq and its regulations 22 Cal Code Regs 22 98000 et seq (Daniel, 2008)

7. Assembly Bill 389 – Hospital language assistance services; Health and Safety Code Section 1259, 2015.

8. –Daniel, Jack, Staff Attorney. (2008). Policy Review. *Fresno Health Consumer Center.* Central California Legal Services (CCLS).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A
TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

WAIVER OF INTERPRETING SERVICES

Complete this form to indicate that you do not want Tulare Regional Medical Center (TRMC) to provide you with an interpreter at no cost to you.

I, _____, understand that I have a right to be provided a free qualified interpreter by TRMC that will allow me to communicate with TRMC nurses and doctors.

I do not want a free qualified interpreter because:

a) I will be communicating using _____

_____

b) I prefer to use the person with me to interpret for me. That person may be my friend, family member or companion. Please fill out who will interpret for you.

Name_____

Address_____

Phone_____

The person is my_____
(Relationship)

I understand that at any time I can change my mind about getting an interpreter. If I change my mind and I do want an interpreter, then I will let any Tulare Regional Medical Center staff know immediately.

Patient's Signature_____Date_____

Paper copies of this document may not be current and should not be relied on for official purposes.
The current version is in Lucidoc at http://lucidoc.cmcinet.org/cgi/doc-gw.pl/ref/cmc:11959

ATTACHMENT B

TULARE LOCAL HEALTH CARE DISTRICT

DBA TULARE REGIONAL MEDICAL CENTER

DOCUMENTO DE RENUNCIA A LOS SERVICIOS DE UN INTÉRPRETE

Complete este formulario para indicar que usted no desea que Tulare Regional Medical Center (TRMC) le provea un intérprete, sin costo para usted.

Yo, _____, entiendo que tengo derecho a que Tulare Regional Medical Center me provea gratis, los servicios de un intérprete calificado, lo cual me permitiría comunicarme con el personal de enfermería y los médicos de Tulare Regional Medical Center.

Yo no deseo los servicios gratuitos de un intérprete calificado debido a que:

a) Me comunicaré usando: _____

_____

b) Yo prefiero que la persona que está conmigo sea mi intérprete. Esta persona puede ser un amigo, familiar, o un compañero. Por favor, complete los datos de la persona que será su intérprete.

Nombre: _____

Dirección: _____

Teléfono: _____

Esta persona es mi: _____
(Indique la relación)

Yo entiendo que puedo cambiar de idea a cualquier momento, sobre los servicios de un intérprete. Caso cambie de idea y quiera un interprete, lo comunicaré inmediatamente al personal de Tulare Regional Medical Center.

Firma del paciente Fecha_____

ATTACHMENT C

GUIDELINES FOR THE USE OF INTERPRETERS

1. Ask patient's permission to use an interpreter.

2. Meet with the interpreter before seeing the patient to provide guidance and instructions.

3. Remind interpreter that all information discussed is **CONFIDENTIAL**.

4. Ask interpreter to use first name.

5. Ask interpreter to interpret patient's and healthcare worker's words as exactly as possible. ***(Add nothing, omit nothing, and change nothing)***.

6. Ask interpreter not to add his/her own comments.

7. Arrange seating in such a way so that the healthcare worker is talking to the patient not to the interpreter.

8. Keep messages simple and factual. Use short phrases and focus on one topic at a time.

    - Avoid jargons, slang, or other complex technical terms.
    - Use terms that are easily understood by everyday people.

9. Give interpreter time to interpret each phrase before continuing. **DO NOT INTERRUPT.**

10. Give patient enough time to answer questions.

11. Do not ask interpreters to do anything other than interpret your words, such as moving the patients, filling out papers, etc. The interpreters are there to interpret only. They are not medically competent or licensed to care for patients in any capacity.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER
POLICY/GUIDELINE MANUAL

ATTACHMENT D

INTERPRETER/TRANSLATOR QUICK REFERENCE

INTERPRETER SERVICE *(If patient does not speak or understand English)*

A. NON-CRITICAL – simple communication and instructions.

1. May be done by a bilingual staff member in any job role.

2. If none in your area, consult ~~the In-house Language Resource List~~other departments.

B. CRITICAL – communication (examples)

- Informed consent – Explaining a medical intervention
- Explaining a diagnosis or prognosis – Recommendation of treatment
- Providing information about blood – Discussion of organ donation
- Discussion of billing or insurance matters – etc.

Interpreters must be:

1. Competent medical interpreters (bilingual staff who have been deemed competent in critical medical information through competency evaluation.)
2. Language Line Service

C. PROCEDURE for use of interpreter:

1. Assess the patient regarding what language he/she speaks (face sheet/armband).
2. Offer the patient free interpreter service provided by the hospital.
   a. Ask patient's permission to use an interpreter
   b. Meet with the interpreter before seeing the patient to provide guidance and instructions.
   c. Remind interpreter all information discussed is **CONFIDENTIAL.**
   d. Ask interpreter not to add his/her own comments.
3. If patient prefers family or friend, ask them to sign a **Waiver** (Minors younger than 18 cannot be used unless emergency)
4. ~~If there are no Tulare interpreters available~~For critical communication and/~~-~~or for a rare language, use the Language Line Service.
5. Staff shall record whether a patient needs interpreter services and the language he/she speaks in the clinical documentation/computer system. Staff will record interpreter~~s~~ name and identification number.

Descriptive Name:	Interpreter-Non-English and Limited English Proficient (LEP) Patients
Descriptive Type:	Revised
Document Number:	10-1040
Attachments:	Four
Author:	Carol Bradford
Typist:	~~Melissa Arend~~Carol Bradford
Creation Date:	09/23/09
Revision Date:	01~~12~~/08~~22~~/18~~4~~
Prev. Dist. Date:	01~~5~~/29~~7~~/15~~0~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	Revisions as required by the Department of Health and Human Services, Office for Civil Rights, Washington DC.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Forms Control

Policy

It is the policy of Tulare Local Health Care District dba Tulare Regional Medical Center to review all paper forms proposed by various hospital departments prior to their inclusion in a patient's chart or meet regulatory compliance requirements. The Hospital Forms Committee is responsible for adhearing to the criteria for the format of forms, and to assure compliance with regulatory standards.

Procedure

The Forms committee is responsible for reviewing new and/or revised forms to determine compliance with hospital standards for format and regulatory (DHS, TJC~~AHO~~, DNV, CMS) requirements regarding content.

1. The Committee will meet ~~the second and fourth Tuesday of each~~ monthly and/or prn.

2. The Committee will ensure adherence to the current Tulare Regional Medical Center graphic standard guidelines ~~as described in the Tulare Regional Medical Center 2009 Logo Standard Guide.~~

3. Committee Members: Director of Materials Management, Director of Medical Records, Compliance, Information Technology, Education, Nursing and Marketing.

4. Approved forms will be returned to the appropriate director. The director will be responsible for obtaining Medical Staff approval, if necessary, and forwarding approved form to Materials Management for printing.

5. Materials Management will be responsible for facilitating language translation on approved forms.

5. Materials Management will maintain a master forms book. All forms approved for inclusion in the medical record will be assigned a control number by Materials Management, and the original form maintained within ~~in~~ Materials Management.

Approved: Forms Control
10-1042

Board of Directors: ~~09/23/09~~
Questions regarding any aspect of this policy/guideline should be referred to Administration

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

REQUEST FOR NEW / REVISED FORM

Tulare Regional Medical Center

Date of Request: ____/___/____

Form Title: _____

Requester: _____ Contact Number:_____

Originated by (committee or person)_____

Department Head Approval (signature):_____ Department: _____

Who will present to Forms Committee? _____

Other Committees/Meetings where this form has been approved:_____

Does this form contain the same information as an existing form(s)? ☐ Yes ☐ No ☐ N/A

Is the form replacing an existing form(s)? ☐ Yes ☐ No Attach the form(s) being replaced.

Who requires this form? ☐ Joint Commission/DNV ☐ DPHS ☐ CMS ☐ Other:

_____

Will this form be added to a patient's chart? ☐ Yes ☐ No

Physicians/Departments using this information?_____

Can this form be utilized throughout the District? ☐ Yes ☐ No

Who is responsible for staff education regarding this form? _____

Will form require translation in a language other than English? ☐ Yes ☐ No

Language(s)_____

Form to be printed by or made available through: ☐ CVBF ☐ **E-Forms** ☐ **TRMC Intranet Forms**

☐ Other:_____

Approximate number of forms used per month (circle one): ☐ 25 -100 ☐ 101-250 ☐ 251-500 ☐ >500

Comments: _____

Provide 10 copies of sample form. Are you familiar with the "Form Standardization Rules"? (See logo usage guide on Intranet in Marketing Files.)

Forms Committee Review Date: ___/___/___ ☐ Approved ☐ Revise ☐ Rejected By:

_____

Committee Comments:_____

_____

Revised 06/09

Descriptive Name: Forms Control

Descriptive Type: Revised

Document Number: 10-1042

Attachments: One

Author: ~~Sherrie Bakke~~Carol Bradford

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 08/13/05

Revision Date: 02/01/18

Prev. Dist. Date: 09/27/05

Committee Review:	Approval Date:	Comments:
Forms Committee	~~06/18/09~~	
Board of Directors	~~09/23/09~~	

Effective Date: ~~09/23/09~~

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Vehicle Parking Policy

To encourage appropriate use of designated hospital parking areas, the following policy is established:

1. There is no fee charged for parking in designated areas. There is a charge to the employee by the towing company for removing vehicles from unauthorized parking areas.

2. Separate and specific parking areas are designated for (see attached map). Parking will be designated by signage:

    a. Patients/Visitors
    b. Handicapped
    c. Physicians
    d. Employees

3. All employees, contracted staff and physicians are issued a parking permit by the Human Resources Department. The permit is to be hung on the rear view mirror. This permit identifies the vehicle to assist Security in monitoring vehicle safety and to ensure employees are parked in designated areas. The permit is designed to transfer from one vehicle to another. Additional permits are not available.

4. Every effort shall be made to return an issued permit to the Human Resources Department upon termination of employment at Tulare Regional Medical Center.

5. Hospital security personnel routinely monitor designated parking areas and will place parking violation notices on those vehicles not authorized to use that parking area. A sample copy of the notice is attached to this policy.

    a. "Parking Violation Notice to Employee" – completed and placed on the vehicle by Security Personnel.

6. A copy of the Parking Violation Notice to Employee is forwarded to the Human Resources Department for the employee's file and a copy forwarded to the employee's Department Director.

Effective Date: ~~04/04/13~~

(10) Administration General:
Vehicle Parking Policy
10-1052

Approved:

Board of Directors: ~~04/03/13~~

7. Employees who receive two (2) parking violations, shall be warned to comply with the Hospital Policy and will be disciplined as per the hospital disciplinary action policy #15-2015. Such violations shall be considered during the employee's annual review.

   A third (3) parking violation will be cause to have the vehicle towed at the employee's expense and further disciplinary action will occur as per the hospital disciplinary action policy #15-2015.

8. Employee vehicles utilizing handicapped parking areas without proper identification will be towed without prior warning or notice at the employee's expense.

9. Employee's not displaying the parking permit in their rear view mirror while on duty will be disciplined as per the hospital disciplinary action policy #15-2015.

10. Employee's who feel they have received a parking violation in error, for example, if an employee is sick and parks in lab parking to get lab work drawn and receives a warning the employee may contact their Manager or Human Resources Department to have the warning removed, if deemed appropriate.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy replaces and supersedes all previous policies concerning this matter and is effective immediately.

DELETE MAP

Tulare Regional Medical Center
Parking Map
10.20.2011

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

NOTICE TO EMPLOYEE

DATE: _____
TIME: _____

Dear Employee:

You have not utilized the proper parking area.

Hospital employee parking is provided in designated areas at no charge. There are also designated parking areas for patient's, handicapped and Physician's.

We ask your cooperation. Please utilize the proper parking area as designated by signs posted at the entrance to each parking area. Please contact your supervisor if you have any question regarding the proper parking area.

We would appreciate your suggestions for improving parking or reasons why you believe you cannot utilize the assigned vehicle parking area. Please write your comments below and return to Human Resources.
Thank you,

COMMENTS:_____

_____

_____

_____

_____

Descriptive Name: Vehicle Parking Policy

Descriptive Type: Revised

Document Number: 10-1052

Attachments: Yes

Author: Brooke Brown

Typist: Jennifer Bridges/Ena Menezes/Andrea Carrasco

Creation Date: 02/15/13

Revision Date: 02/01/18

Prev. Dist. Date: 07/28/11

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care (EOC)	~~02/28/13~~	
Board of Directors	~~04/03/13~~	

Effective Date: ~~04/04/13~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Nursing Services, Emergency Services, Mortuaries and Coroner

FROM: Administration

SUBJECT: Patient Deaths and Physician Pronouncement

PURPOSE:

This policy covers the responsibilities involved when a patient expires. If the patient expires in the Emergency Department or is Dead on Arrival, Emergency Services will be responsible for carrying out these requirements. If the patient expires on the nursing units, in O.R., or in the Post Anesthesia Services Unit (PACU), the responsibility will be Nursing Services. Regardless of the department, the Nursing Supervisor shall always be notified of any patient death.

PROCEDURE:

I. In House Deaths:

A. The patient must be pronounced dead by the attending physician. If the attending physician is unable to pronounce the patient, he/she shall contact another physician in a timely manner to pronounce the patient.

B. The attending physician can request pronouncement of death by a designated Certified Registered Nurse, as long as the patient meets the criteria as set for in policy #20-20,003 “Standardized Procedure: Pronouncement of Death by a Registered Nurse. A current list of “RNs Certified in Pronouncement of Death” can be located in the Nursing Supervisor’ office.

II. Emergency Department Deaths:

The Emergency Department physician may pronounce the patient dead. The Emergency Department physician shall contact the patient’s personal physician and inform him of the death.

Effective Date: ~~10/24/02~~	(10)	Administration General:
Approved:		Patient Deaths and Physician Pronouncement
Medical Executive Comm.: ~~10/9/02~~		10-1053
Board of Directors: ~~10/23/02~~		

III. Ambulance Call Deaths:

The patient must be taken to a medical facility to be pronounced dead by a physician if a coroner is not available at the scene.

IV. Coroner's Cases:

A. The following cases must be reported to the Coroner immediately but in all cases within one (1) hour of the time of death:

1. Homicide
2. Suicide
3. Accidents
4. Injury
5. Grounds to suspect that the death occurred in any degree from criminal act
6. No physician in attendance
7. In the continued absence of the physician (not having seen the patient within twenty (20) days prior to the death)
8. Medical attendance less twenty-four (24) hours
9. Physician unable to state the cause of death
10. Poisoning (food, chemical, drug, therapeutic agents, etc.)
11. Occupational deaths
12. All deaths in the Operating Room
13. All deaths in which the patient had not fully recovered from an anesthetic, whether in surgery, PACU, or elsewhere
14. All solitary deaths (unattended by a physician or family member
15. All deaths in which the patient was comatose throughout the period of the physicians' attendance, whether at home or in the hospital
16. All deaths of unidentified persons
17. All state hospital deaths
18. Known or suspected contagious disease, constituting a public hazard.
19. Where the suspected cause of death is Sudden Infant Death Syndrome.
20. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation, or aspiration.

B. If foul play is suspected the law enforcement agent, with jurisdiction, must be notified and the environment must not be disturbed to prevent loss of valuable evidence and information.

C. All evidence of treatment rendered (IV, ET tubes) shall be left intact until the coroner has visited or released the body.

V. Notification:

A. The attending physician and/or his designee shall notify the next of kin. Hospital personnel should give out no information about the deceased to anyone except the immediate family and then only after the attending physician has notified the next of kin.

B. In all cases the Mortician, as selected by the Coroner or the family, must be informed within one (1) hour after the death has occurred.

When the family does not have a choice of mortician, it is TRMC policy to provide a list of available morticians and allow the family to select one of their choice.

C. Inquiries about the deceased should be referred to the family. It is permissible to report the death of a patient provided the next of kin has been notified first.

VI. Consents:

A. The next of kin must sign a BODY RELEASE in duplicate. The original shall be placed on the chart and the copy given to the mortician.

B. A CONSENT FOR AUTOPSY should also be signed by the next of kin in duplicate. As a professional courtesy, the expired patient's attending physician shall notify the pathologist that an autopsy has been requested prior to calling the mortician. The original consent shall be placed on the chart and a copy of the consent form shall be made available for the pathologist at the time of the autopsy. The attending physician shall be notified of time and place of the autopsy.

VII. Personal Effects:

A. All personal effects of the deceased shall be safeguarded and recorded:

a. List each item of clothing
b. List each item of jewelry by color, not type (i.e., yellow ring, not gold ring).
c. Any monies shall be counted by two (2) people and the amount written on the form with both persons signing the form.

B. If the death is a coroner's case, the personal effects shall be given to the coroner. The next of kin or a relative shall be notified of this requirement and

that information charted. This should be done as soon as possible to avoid possibility of misplacing the effects.

VIII. View The Body:

If the next of kin want to view the deceased, the body may be viewed in the patient's room or in the morgue.

IX. Religious Requirements:

Attention must be given to the religious requirements of the deceased and/or the next of kin. If family or friends are present, their desires shall be determined and complied with if possible.

If the deceased has no family or friends present and is known to be Catholic, a priest shall be summoned immediately. If the deceased's religion is unknown, the Hospital Chaplain shall be called and he shall determine the appropriate religious requirements.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient Deaths and Physician Pronouncement

Descriptive Type: Revised

Document Number: 10-1053

Attachments: None

Author: Julie Grisham~~Julie Gresham~~

Typist: Carol Bradford~~Julie Gresham~~

Creation Date: 5/1/91

Revised Date: 01/18/18

Prev. Dist. Date: 9/30/91

Committee Review and Approval:	Approval Date:	Comments:
Family Practice Committee	N/A~~09/25/02~~	Date change only
Emergency Medicine Committee	N/A~~09/06/02~~	Date change only
Medicine Committee	N/A~~08/13/02~~	Date change only
MEC	N/A~~10/09/02~~	Date change only
Board of Directors	~~10/23/02~~	

Effective Date: ~~10/24/02~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Department Managers

FROM: Administration

SUBJECT: Food and Beverage Control

In an effort to maintain Hospital cleanliness, to preserve a professional appearance, to control the spread of insects and other pests, and to contain additional costs, the following policy is established:

1. Employees and visitors may consume food and beverages only in the cafeteria or other designated areas (such as the outdoor patios).

   Employee workstations are NOT designated areas for food consumption. All staff shall take their lunch break and rest periods away from their workstations.

2. Beverages are not to be consumed at workstations viewable by patients, visitors or the general public (such as nursing stations, reception areas, treatment areas, etc.).

3. Spillage, whether by visitors, patients or employees shall be reported immediately to the Environmental Services Department. Employees are responsible for insuring all spills are cleaned up immediately. The Environmental Services Department may assist.

Enforcement of this policy will be at the discretion of each department manager.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Board of Directors: ~~03/25/09~~

Descriptive Name: Food and Beverage Control

Descriptive Type: Revised

Document Number: 10-1056

Attachments: None

Author: Sara Martinho ~~Sara Martin~~

Typist: ~~Hillary Keith~~Andrea Carrasco/Ena Menezes

Creation Date: 10/06/06

Revision Date: 02/01/18

Prev. Dist. Date: 10/25/06

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~1/14/2009~~	Date change only
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders – 5 and Post to Intranet site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Use of Hospital Vehicles

In an effort to assure the proper scheduling, use, repair and maintenance of hospital vehicles, the following policy is established.

Hospital vehicles are provided for hospital business use only, and only by hospital employees who possess a current California drivers license and are covered by the TRMC automobile insurance program. The Hospital reserves the right to restrict or deny use of hospital vehicles to an employee based on the employee's driving record or other insurance considerations

I. Hospital vehicles may not be used by hospital employees if members of the employee's family and/or any other non-hospital person(s) are to be occupants. Hospital insurance does not cover members of the employee's family or any other non-hospital personnel in the hospital vehicle.

Should an employee wish family members or any other non-hospital personnel to accompany him/her on a trip, such as to a seminar, the employee must request approval to use his/her own vehicle and must apply for mileage reimbursement.

II. Employee using hospital vehicles must call Engineering to reserve the vehicle. Before taking the vehicle, employees must also complete and sign the log sheet before receiving the keys and when returning the keys. A valid driver's license must be verified by employee maintaining log sheet. Keys for the hospital vehicle can be picked up at PBX at any time. Keys should be returned to PBX.

Hospital vehicles shall be returned to the hospital grounds immediately upon completion of the employee's approved reason for use. These vehicles shall not be taken to the employee's residence and returned later or the next day.

Any change(s) such as destination, date and time expected to return or nature of hospital business as written on the log shall NOT be made without prior Engineering approval.

A. The following information must be provided in the log:

1. Employee name
2. Expiration date of driver's license and driver's license verified by Risk Manager and or Human Resources.
3. Which vehicle used
4. Destination
5. Date vehicle used
6. Time keys picked up
7. Time keys returned
8. Mileage upon return
9. A work order completed, if necessary
10. Date and time expected to return
11. Nature of hospital business
12. Passenger(s)

B. The log and vehicle keys are available in the following areas:

1. Switchboard (PBX)
2. Engineering Office

III. Users of the hospital vehicles are responsible for notifying Engineering of any problem(s) with the vehicle. A Hospital Work Order must be completed, describing the problem, and returned to Engineering.

IV. Seat belts must be worn at all times.

V. Vehicle registration and insurance information is located in the glove compartment of each vehicle.

VI. In case of an accident with the hospital vehicles and depending on injuries, if any, the employee shall:

A. Render appropriate aid to any injured parties and insure an ambulance is summoned if needed.

B. Notify the police immediately.

C. Write down the name(s), address(es), and phone number(s) of driver(s) and witness(es).

D. Write down license plate numbers of vehicles involved in the accident.

E. Request to see driver license(s) and write down the number(s).

F. Do not admit to any fault and do not discuss the accident with anyone except appropriate law enforcement officers, hospital Administration and hospital insurance company representatives.

G. Note the extent of damage done to other vehicles and injuries to other people.

H. Notify hospital Engineering and or Administration AS SOON AS POSSIBLE.

I. Information obtained in c, d, and e above shall be forwarded to Administration as soon as possible.

VII. Do not exceed the speed limit safe for conditions.

VIII. Drive defensively.

IX. Lock doors when in vehicle and when vehicle unattended.

X. Only carry as many passengers as there are seatbelts.

XI. Never transport passengers in the bed of a truck.

XII. Must follow DMV Code.

XIII. No smoking.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Use of Hospital Vehicles

Descriptive Type: Revised

Document Number: 10-1057

Attachments: None

Author: Lionel Machado/Andrea Carrasco/Ena Menezes

Typist: Melissa Arend

Creation Date: 02/28/02

Revision Date: ~~08/21/14~~ 02/01/18

Prev. Dist. Date: 10/26/06

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	N/A~~08/21/14~~	Date change only
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Hospital Gas Credit Card Usage

1. Hospital gasoline credit cards are available only when using hospital vehicles and advances for mileage has not been obtained.

2. Credit cards will not be issued when an employee uses their own vehicle.

3. Advances for mileage shall be made prior to all scheduled conferences or scheduled hospital business travel, utilizing the Seminar/Conference Travel - Expense Account form included in hospital policy #10-1031.1 Expense Consideration and Reimbursement for Workshop, Seminars, Conferences, Meetings and other Hospital Business Related Functions

4. Should an employee incur "out of pocket expenses" while driving either the hospital car or their own vehicle while on hospital business, a reimbursement form shall be completed and for approval by the Department Director. Receipts must be attached to the reimbursement form included in hospital policy #10-1031.1 to facilitate reimbursement. Mileage reimbursement rate shall be ~~forty-two~~ fifty-four and a half cents ($.~~42~~54~~2~~5) per mile. Timely reimbursements will be processed by Accounts Payable.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Board of Directors: ~~01/03/07~~

Descriptive Name:	Hospital Gas Credit Card Usage
Descriptive Type:	Revised
Document Number:	10-1057.1
Attachments:	None
Author:	~~Robert Montion/~~Robert Montion/Andrea Carrasco/Ena Menezes
Typist:	~~Julie Gresham~~Andrea Carrasco
Creation Date:	11/01/00
Revision Date:	02/01/18
Prev. Dist. Date:	2/28/02

Committee Review:	Approval Date:	Comments:
Board of Directors	~~01/03/07~~	

Effective Date:	~~01/04/07~~
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Tulare County Sheriff's Office, Tulare Police Department, California Highway Patrol

FROM: Administration

SUBJECT: Patients Admitted on Law Enforcement Hold

In an effort to ensure appropriate handling of patients and maximize communications, the law enforcement agency requesting an admission of one of their patients to Tulare District HealthCare System is expected to provide hospital personnel with the following information:

1. The patient is or is not prone to violence
2. The patient is or is not a known drug abuser
3. A law enforcement officer will or will not be posted to guard the patient

The law enforcement agency is expected to complete and sign the "Law Enforcement Agency Patient Hold" / "Law Enforcement Agency Notice of Discharge" form at the time of the patient admission designating who is to be notified in event of the patient's release (see **attachment**, "Law Enforcement Agency Patient Hold / Notice of Discharge" form).

It is permissible to notify the Law Enforcement Agency of a patient's discharge as long as the requesting agency has completed and signed the "LAW ENFORCEMENT AGENCY NOTICE OF DISCHARGE" form. The completed form shall be placed in the patient's chart. If indicated, it is acceptable to notify the law enforcement agency without notifying the patient of the pending discharge. This must also be indicated on the form by the requesting agency.

Patients with a posted police guard will be placed in a private room. No visitors or phone calls will be allowed. Law Enforcement Officers are expected to know the patient's medical care routine so they will not interfere with nursing care.

According to the recommendations from the local law enforcement agency, restraint restrictions will be placed upon the patient (as physical condition allows) under the direct supervision of the local law enforcement agency. TDHS restraint policy will be followed.

Effective Date: ~~11/20/14~~ (10) Administration General: Patients Admitted on Law Enforcement Hold 10-1059

APPROVED:

Medical Executive Comm.: ~~11/05/14~~

Board Of Directors: ~~11/19/14~~

The Case Manager will maintain contact with the patient and the law enforcement agency under whose care the patient is entrusted. Discharge planning will be conducted with the assistance of the law enforcement agency, with all discharge planning issues deferred to the state/county/local law enforcement agency. The patient's length of stay will be dependent upon his/her clinical condition and determination of stability of transfer.

The Hospital realizes the police agency assumes no financial liability for anything considered "extra".

Hospital staff shall not be expected to nor"guard" patients. Law Enforcement officers shall "guard" all patient's within the confines of hospital grounds..

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

PATIENT HOLD

TO: _____

PATIENT'S NAME: _____

The above subject is in the custody of the:

- ☐ Sheriff's Dept.
- ☐ Tulare Police Dept.
- ☐ Highway Patrol
- ☐ Other _____

Please contact the above department prior to the release or transfer of the subject.

_____ _____
LAW ENFORCEMENT OFFICER DATE

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

LAW ENFORCEMENT AGENCY

NOTICE OF DISCHARGE

TO:_____
(Agency to be Notified of Discharge)

LAW ENFORCEMENT
REPRESENTATIVE:_____

LAW ENFORCEMENT PHONE#:_____

PATIENT'S NAME:_____

PATIENT'S DOB:_____

_____ _____
LAW ENFORCEMENT OFFICER DATE

Descriptive Name: Patients Admitted on Law Enforcement Hold

Descriptive Type: Revised Policy

Document Number: 10-1059

Attachments: Two

Author: Lionel Machado

Typist: Melissa Arend

Creation Date: 08/29/02

Revision Date: ~~08/21/14~~4/24/18

Prev. Dist. Date: 05/25/06

Committee Review and Approval:	Approval Date:	Comments:
EOC	~~08/21/14~~n/a	Date change only
MEC	~~11/05/14~~n/a	Date change only
Board of Directors	11/19/14	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments: Copies forwarded to:
Tulare County Sheriff's Department, Asst. Sheriff Wright
2404 W. Burrel, Visalia, CA 93291, 733-6211

Tulare Police Department, Captain Larry Brooksher
260 South M Street, Tulare, CA 93274, 684-4238

California Highway Patrol, Lt. Rob Brunell
5025 W. Noble Ave., Visalia, 93277, 734-6767

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Assault and Abuse Reporting Requirements (HIPAA)

DELETE

POLICY:

Hospitals and other health care providers are required by law to report assault and abuse. Abuse of an elder or a dependent adult includes physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. Abuse includes injuries by deadly weapon, rape, child abuse, elder abuse, dependent adult abuse, and injuries/conditions resulting from licensed health facility.

Abuse does not include the use of any reasonable and necessary force that may result in an injury used by a peace officer acting within the course of his or her employment as a peace officer.

Elders are persons 65 years of age or older. Dependent adults are persons between ages 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly states that any person between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital or other 24-hour health facility is a dependent adult.

Reports are required to be made when a health practitioner, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows:

1. A person suffering from any wound or other physical injury where the injury is by means of a firearm, whether inflicted by the patient him/herself or by another person.

2. A person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct. (Penal Code Section 11160).

II. MANDATED REPORTERS:

Persons required to report abuse include:

1. Health Care Practitioner including a physician, licensed nurse, social worker, emergency medical technicians, paramedic's, or other persons certified pursuant to Health and Safety Code Section 1797.

2. Clergy member.

3. Any person who is not considered a mandated reporter who has knowledge of or reasonably suspect's abuse or neglect may file a report.

III. FAILURE TO REPORT:

Penal Code Section 11162 states that any person required to report injuries by firearms, assaultive or abusive conduct but who fails to do so is guilty of a misdemeanor, punishable by imprisonment in the county jail not exceeding six months or by a fine not exceeding $1000.00, or both.

IV. TIMING OF REPORT:

A report by telephone must be made immediately or as soon as practically possible. A written report must be prepared and sent to a local law enforcement agency within two working days.

A report must be made even if the person who suffered the injury has died, regardless of whether or not the injury or assaultive or abusive conduct was a factor contributing to the death and even if the evidence of the conduct of the perpetrator of the injury or assaultive or abusive conduct was discovered during an autopsy.

V. NOTIFICATION OF VICTIM:

If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made, unless:

1. The health care provider believes, in the exercise of professional judgment, that informing the patient would place him or her at risk of serious harm; or

2. The health care provider would be informing a personal representative, and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury, and that informing the personal representative

would not be in the best interest of the patient as determined by the provider in the exercise of professional judgment.

Verbal notification to the patient is sufficient. A report must be made even if the patient objects.

If the patient was not a victim of abuse, neglect or domestic violence (for example, the patient was an accident victim or attempted suicide), the patient need not be notified that a report has been or will be made.

VI. CONTENTS OF REPORT:

The report must include, but not be limited to, the following:

1. The name of the injured person, if known.

2. The injured person's whereabouts.

3. The character and extent of the person's injuries.

4. The identity of any person the injury person alleges inflicted the wound, other injury or assaultive or abusive conduct upon the injured person.

If the patient was a victim of abuse, neglect or domestic violence (except child abuse), optional information may not be disclosed unless:

1. The victim agrees to the disclosure; or

2. The health care provider, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the victim or other personal victims; or

3. If the victim is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information to be disclosed is not intended to be used against the victim and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the victim is able to agree to the disclosure.

The form "Report of Injuries by Deadly Weapon or Assaultive/Abusive Conduct" may be used to make the written report. (See attachment).

VII. PATIENT~~'~~S WHO ARE VICTIMS OF DOMESTIC VIOLENCE:

Patients admitted to the Emergency Department and/or admitted, as an in-patient will be screened for domestic violence.

A Social Worker is available to respond to suspected cases of domestic violence, five days a week, for patients seen in the Emergency Department and for in-patient's, from 0800 to 1630 hours weekdays and may be contacted via ~~Patient and Family~~Social Services. The following information will be provided:

a. Educate the individual about the cycle of domestic violence, including the escalating nature of abuse. (Injury documentation record)

b. Inform the suspected victim of available resources, including financial, legal, and shelter resources. (Guidelines for the women in a battering situation)

c. Assist the victim in developing a safety plan. The social worker assessment will also include an assessment of risk factors including child abuse and neglect, substance abuse, and suicidal and homicidal ideation. (Safety plan)

After hours and weekends, the ED staff will provide victims with above stated available resources.

VII. MEDICAL RECORD DOCUMENTATION:

Penal Code Section 11161 recommends (but doesn't require) that the medical record of a person who is the subject of a report include the following:

1. Any comments by the injured person regarding past domestic violence or regarding the name of any persons suspected of inflicting the wound, other physical injury, or assaultive conduct upon the person.

2. A map of the injured person's body showing and identifying injuries and bruises at the time of the health care including any photographs, and a copy of the law enforcement reporting form.

VIII. STAFF EDUCATION:

Tulare Local Health Care District ~~HealthCare System~~ staff shall receive education and training in dealing with victims of domestic violence and other forms of abuse. Staff shall learn the signs and symptoms related to domestic violence and the appropriate intervention process that is recommended by its department.

IX. VIOLENCE AGAINST HEALTH CARE~~HOSPITAL~~ PERSONNEL:

Under Health and Safety Code Section 1257.7(d), acts of assault or battery against on-duty health care~~hospital~~ personnel are subject to reporting requirements. Any act of assault or battery against any on-duty health care~~ospital~~ personnel that results in injury or involves the use of a firearm or other dangerous weapon must be reported to the local law enforcement agency.

Either the employee or an agent of the district~~hospital~~ must make a report within 72 hours of the incident. This may be reported verbally or in written form. If in writing, the attached form "Assault or Battery Against On-Duty Hospital Personnel" may be used.

DISCLOSURE ABOUT VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE (HIPAA):

1. District~~The hospital~~ staff is allowed to disclose in certain circumstances, protected health information about a patient whom the staff reasonably believes to be a victim of abuse, neglect, or domestic violence. Those circumstances under which the staff is allowed to report abuse are:

    a) If the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law.

2. District~~The hospital~~ staff is allowed to disclose protected health information related to abuse if the patient agrees to such disclosure may only be made to a public authority specifically identified in the law authorizing the report.

    a) District~~The hospital~~ staff is allowed to disclose protected health information related to abuse if the patient agrees to such disclosure. If the staff is considering disclosing protected health information in an abuse situation they should try to obtain the patient's agreement whenever possible.

    b. District~~The hospital~~ staff is allowed to disclose protected health information about a patient without the patient's agreement if the disclosure is expressly authorized by state statue or regulation and either:

        1. District~~The hospital~~ staff, in the exercise of its professional judgment, believes that the disclosure is necessary to prevent serious harm to the patient or to other potential victims; or

        2. If the patient is unable to agree due to incapacity, a law enforcement or other public official authorized to received the report represents that the protected health information for which disclosure is sought is not intended to be used against the patient, and that an immediate enforcement activity that depends on the disclosure would be materially and adversely affected

by waiting until the patient is able to agree to the disclosure. District~~The hospital~~ staff may exercise discretion, consistent with professional judgment as to the patient's best interest, in deciding whether to make the requested disclosure.

3. Disclosure may be made only if it is expressly authorized by state statute or regulation.

4. Disclosure by the staff to any governmental authority authorized by state law to receive reports of such abuse, neglect, or domestic violence is allowed.

5. The staff must inform the ~~hospital~~ Privacy Officer when they believe that a disclosure should be made.

6. The Privacy Officer will have the responsibility of determining if the disclosure should be made, for conveying it to the recipient, and providing the appropriate documentation to the patient's file.

7. District~~The hospital~~ staff must inform the patient in all of the situations described previously if the district~~hospital~~ has disclosed protected health information to report abuse, neglect, or domestic violence.

8. This may be done orally. Written notification is not required due to the sensitivity of abuse situations and the potential for the abuser to cause further harm to the patient.

9. Whenever possible, district~~the hospital~~ staff should inform the patient at the same time that they determine abuse has occurred and decide that the abuse should be reported. In cases involving patient incapacity, we encourage the staff to inform the patient of such disclosures as soon as it is practicable to do so.

10. There are two exceptions to the requirement to inform the patient about a report to a government authority, one based on concern for future harm and one based on past harm.

    a. District~~The hospital~~ staff need not inform the victim if the ~~hospital~~ staff in the exercise of professional judgment believes that informing the patient would place the individual at risk of serious harm. This exception is necessary to address the potential for future harm, either physical or emotional, that the patient may face from knowing that the report has been made.

    b. The staff may choose not to meet the requirement for informing the victim, if the staff actually would be informing a personal representative (such as a parent of a minor) and the staff reasonably believes that such person is responsible for

the abuse, neglect, or other injury that has already occurred and that informing that person would not be in the individual's best interests.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

EMOTIONAL/PHYSICAL ABUSE ASSESSMENT SCREEN

Have you ever been emotionally or physically abused by someone important to you? YES - NO -

If YES to above, were you pregnant at the time? YES - NO -

WITHIN THE LAST YEAR, have you been hit, slapped, kicked or otherwise hurt by someone? YES - NO - If YES, by whom? _____

Total number of times _____ If YES, mark the area of injury below:
Score each incident according to the following scale:

(1) Threats of abuse including use of a weapon
(2) Slapping, pushing; no injury and/or lasting pain
(3) Punching, kicking, bruises, cuts and/or continuing pain
(4) Beating up, severe contusions, burns, broken bones
(5) Head injury, internal injury, permanent injury
(6) Use of weapon; wound from weapon

(If any of the description for the higher number apply, use the higher number).

WITHIN THE PAST YEAR, has anyone forced you to have sexual activities? _____ YES - NO -

If YES, by whom? _____

5. Total number of times: _____ If answers are YES, Signs and symptoms _____

If NO, do you feel like it is okay to say "NO" to your partner's advances? YES - NO -

Are you afraid of anyone you listed above? YES - NO -

Do you feel like you have to "walk on egg shells" around anyone in your home? _____ YES - NO -

Has anyone in your home ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education? YES - NO -

Has anyone in your home ever destroyed things you care about? YES - NO -

Does anyone in your home try to control your behavior? YES - NO -

We all argue at home. What happens when you and someone in your home disagree?
_____
_____

~~11. Do you have weapons in your home? YES - NO -~~

~~If YES, has anyone in your home ever threatened to use them when he was angry? YES - NO -~~

REPORT OF INJURIES BY DEADLY WEAPON OR

ASSAULTIVE/ABUSE CONDUCT (Penal Code 11160)

Injured Person (*if known*): _____

Injury (*state character and extent of injuries*): _____

_____

_____

_____

_____

_____

Whereabouts of Injured Person:

_____

_____

_____

Identity of Person Alleged to Have Inflicted Injury (*name of person, if known*):

_____

_____

_____

Date: _____

Signature: _____

(*Name of reporting health practitioner*)

Hospital: ***Tulare District HealthCare Systems***

Address: ***869 N. Cherry Ave.***

Tulare, CA 93274

A telephone report must be made to local law enforcement immediately.

This written report must be filed with local law enforcement within two working days.

ASSAULT OR BATTERY AGAINST HOSPITAL PERSONNEL

(Hospital Letterhead)

(Date)

(Local Law Enforcement Agency Name)

(Address)

Dear _____:

Pursuant to California Health and Safety Code Section 1257.7. we are reporting that an assault and/or battery against on-duty hospital personnel took place on

***(*date*)* _____.**

Check the following:

1. ***The incident ☐ did* ☐ did not result in injury to the employee.***

2. ***The incident ☐ did* ☐ did not involve the use of a firearm or other dangerous weapon.***

Please contact _____at _____
if you have any questions.

Sincerely,

(Signature)

(Name)

(Title)

**Report is required if either of these boxes is checked*.

TULARE LOCAL HEALTH CARE DISTRICT
dba Tulare Regional Medical Center

POLICY/GUIDELINE- MANUAL

Descriptive Name: Assault and Abuse Reporting Requirements (HIPAA)

Descriptive Type: Revised

Document Number: 10-1060.1

Attachments: Yes- 2

Author: ~~Julie Gresham~~

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 1-12-04

Revision Date: 01/16/18

Prev. Dist. Date: ~~1/17/00~~

Committee Review and Approval:	Approval Date:	Comments:
E & O	~~7/8/04~~	
MEC	~~7/14/04~~	
Board of Directors	~~7/28/04~~	

Effective Date: ~~7/29/04~~

Forward To: Policy Binders – 5 and Intranet

Disposition: Copy and Distribution –Jody Ellis

Comments: Information referenced with the CHA 2003 Consent Manual

TULARE LOCAL HEALTH CARE DISTRICT
Dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

DELETE

SUBJECT: Patient Abuse/Harassment

Pursuant to Patient Right Guideline 483.13(c) (3) Tulare Regional Medical Center shall prohibit all forms of abuse, neglect (as a form of abuse) and harassment whether from staff, other patients or visitors. Human Resources, Security, Nursing Department and support staff shall all participate in the effort to provide a safe environment to patients receiving medical care and services.

Abuse Defined
Abuse is defined as the willful infliction of injury, unreasonable confinement, neglect, intimidation, sexual or punishment with resulting physical harm, pain or mental anguish. This includes staff neglect or indifference to infliction of injury or intimidation of one party by another.

Procedure
All incidents must be reported to CEO or designee (Nursing Supervisor, Department Manager) immediately and should be documented on a Quality Review Report. An investigation shall be made immediately and the findings of the investigation shall be reported to the CEO within five (5) working days of incident(s). The CEO or designee shall report incident to the State. If the investigation reveals that suspected or actual abuse occurred, the CEO or designee will notify state and federal agencies and the local police department. The report must include, but is not limited to:

a. The name of the patient involved.

b. The date and time the incident occurred.

c. The circumstances surrounding the event.

d. Where the incident took place.

e. The name(s) of any witnesses.

f. The name of the person (s) charged with committing the act.

g. Recommendation for correction of incident.

Effective Date: 08/25/11

(10) Administration
General
Patient Abuse/Harassment
10-1060.2

APPROVED:

Medical Executive Comm.: 08/10/11

Board Of Directors: 08/24/11

h. Other information as requested or appropriate for reporting purposes.

The following procedures are for the prevention and safety of the patient while at the Tulare Regional Medical Center.

Prevention
The hospital shall have sufficient staff on duty, especially during the evening, nighttime, weekends and holiday shifts, to take care of the individual needs of all patients. Sufficient staff will be met by following acuity system.

Screening
Human Resources shall screen new hires by performing background checks for history of abuse, neglect or domestic violence. If history found, potential employee shall not be hired or retained. Each manager will verify the past ten (10) years of work experience or as far back as the applicant has listed. If unable to obtain the information, this will be noted and the manager will then be required to have two personal reference checks.

Identifying and Training
The hospital shall provide a mechanism in the form of employee training, to provide staff with the needed knowledge on the recognition of events and occurrences of abuse and neglect. Staff shall be informed of requirements of reporting, prevention, intervention and detection.

Protection
The hospital shall assure protection of patients from abuse during investigation by increasing nursing to patient ratio, hospital security, local police department, etc.

Investigation
The hospital assures a timely and thorough investigation of all allegations of abuse, neglect or mistreatment. The CEO will assure the timeliness of this operation as outlined above and as stipulated by the time frame.

Report / Response
The hospital shall assure that any and all incidents of abuse, neglect, mistreatment or harassment are reported according to policy # 10-1035.1 “Mandated Reporting Requirements”; and that information will be carefully analyzed and the appropriate corrective or disciplinary action exercised in the matter.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Patient Abuse/Harassment

Descriptive Type: Revised

Document Number: 10-1060.2

Attachments: None

Author: Ruben Rojas/Brooke Brown/Andrea Carrasco/Ena Menezes

Typist: Julie Gresham/Gillian Busch

Creation Date: 07/16/10

Revision Date: 02/01/18

Prev. Dist. Date: 05/25/06

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee	06/10/11	
MEC	08/10/11	
Board of Directors	08/24/11	

Effective Date: 08/25/11

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

dba(Tulare Regional Medical Center ~~District HealthCare System) (TDHS)~~

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Utilization Review Program, Business Office, Medical Records, and Third Party Insurance Representatives

FROM: Administration

DELETE

SUBJECT: Recognition of Third Party Payer Related PRO

Tulare Local Health Care District recognizes the use of Professional Review Organizations (PROθ) by third party payers.

It is the policy of Tulare Local Health Care District to recognize and cooperate with established PRO's as follows:

1. Pre-admit reviews for elective cases.

2. Same day or next working day notification of emergency admissions.

3. Concurrent and extended stay review if the Tulare Local Health Care District Utilization Review is conducted by the in-house U.R. Program staff (delegated) or if the PRO has designated a short-range future date in which the in-house program will begin this review (delegated status is imminent).

4. The PRO may review cases after discharge (retrospective review test) to verify appropriateness of the admit and stay (delegated concurrent review); if there is agreement, reimbursement will not be affected (without recourse).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Recognition of Third Party Payor Related PRO
Descriptive Type:	Revised
Document Number:	10-1068
Attachments:	None
Author:	Tina Anthony/Robert Montion Andrea Carrasco/Ena Menezes
Typist:	Debra Campbell
Creation Date:	3/20/03
Revision Date:	02/01/18
Prev. Dist. Date:	5/25/00
Revision Notes:	General Board 7/23/03
Effective Date:	7/24/03
Forward To:	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Debra Campbell
Comments:	Send 200 copies of Memo with list of policies approved by Board of Directors to HR for payroll distribution
Date Completed:	7/25/03

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Department and Medical Staff

FROM: Administration

SUBJECT: Definition of Patient Categories

Because of record keeping, reporting, and billing requirements of the many agencies we deal with, it is necessary to define our various patient status categories (i.e., inpatient and outpatient).

To this end, the following definitions shall apply and are effective immediately:

A. INPATIENT:

A patient who has been FORMALLY ADMITTED, pursuant to hospital policy and procedure, to an inpatient hospital bed and for whom general nursing and other related services are planned and whose stay is expected to be ~~24~~ 48 hours or more, including through the midnight census count.

Such patients are admitted with the intent and expectation of staying ~~24~~ 48 hours or more. However, the patient may not stay the expected time (i.e., they are transferred to another hospital, expire, or are discharged because of false labor, surgery postponement, etc.). Such patients shall remain in the inpatient category and an inpatient room charge and an inpatient census day shall be recorded.

B. OUTPATIENT:

1. Emergency Outpatient:
   A patient registered for care with the hospital Emergency Department because they have a condition requiring immediate examination and/or treatment. Such patients are not normally expected to be admitted as an inpatient or occupy a bed in the hospital. These patients may be held for a period of time in the Emergency Department for observation. If so, an hourly observation charge will be billed to the patient. If the patient requires formal inpatient admission, the Emergency Department visit will first be recorded. The inpatient admission will then be recorded. If the time of confinement is expected to exceed 23 hours, the patient shall be converted to inpatient status.

Board of Directors: ~~12/28/05~~

2. Referred Outpatient:

   A patient registered with the hospital on an outpatient basis for diagnostic and/or therapeutic services based on a physician referral. The patient does not require services of the Emergency Department staff, the Emergency Department physician, or any other service delivered by the hospital prior to the diagnostic and/or therapeutic services as ordered by the physician. The referred outpatient visit will be recorded for each appearance in the designated hospital ancillary department. (Example: a physician refers a patient to the hospital for a lab test and for an EKG. Each department, Lab and Cardiology, shall count one visit for that patient in their department as a referred outpatient visit.)

3. Outpatient Short Stay/Observation:

   A patient registered with the hospital for one or more hospital services listed in (a) and (b) below. The patient is registered with the intent and expectation of occupying a hospital bed for less than ~~24~~ 48 hours, including any bed area specifically assigned for ambulatory patient services. (Refer to Policy #10-1072.1)

   An outpatient census day will be recorded for each patient visit, in each program, and maintained as a separate count from the inpatient census days, admissions, and discharges.

   Outpatient Short Stay/Observation programs include:

   a. Hospital Ambulatory Surgery

      The patient is registered for outpatient surgery procedure(s). The expected stay is less than 24 hours.

   b. Hospital Medical Diagnostic Procedure(s) and Observation

      Such patients are registered for diagnostic procedures or observation with the intent and expectation of staying less than 24 hours. (Refer to Policy #10-1072.1)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Definition of Patient Categories

Descriptive Type: Revised

Document Number: 10-1072

Attachments: None

Author: ~~Nancy Korovilas / Meade Hallock~~ Charlene Dawson

Typist: ~~Julie Gresham~~Ena Menezes

Creation Date: 8/04/01

Revision Date: 02/05/18

Prev. Dist. Date: 02/28/02

Committee Review and Approval:	Approval Date:	Comments:
Utilization Review	~~09/22/05~~	
Legal Counsel	~~10/14/05~~	
MEC	~~12/14/05~~	
Board of Directors	~~12/28/05~~	

Effective Date: ~~12/29/05~~

Forward To: Policy Binders and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Identification of and Disposal of Excess Hospital Equipment and/or Supplies

In order to clarify the law for and to provide a procedure for disposal of hospital assets, such as excess and outdated equipment and unused un-expired supplies, the following policy is established.

The Hospital Board of Directors has the sole authority to approve disposal of hospital assets, such as excess and outdated equipment and unused un-expired supplies.

1. All departments determining they have unusable equipment shall notify the Materials Management Department in written memo form detailing the equipment description, model number, and hospital inventory number, if any.

2. The Materials Management Department shall prepare a list of surplus or outdated equipment, assets and unused supplies and forward to Administration for presentation to the Board of Directors.

3. Administration will be present for approval during a regular meeting of the Hospital Board of Directors the list of items proposed for disposal.

4. The Board is solely empowered to declare the items surplus, unusable by the Hospital and authorize their disposal. The manner is which items are to be disposed of will be described in the Board of Directors action, including:

    a. Donation
    b. Sale to Vendors
    c. Destroyed
    d. Trade-in

5. Materials Management shall be responsible for notifying and providing the Finance Department a list of those items approved for disposal.

Effective Date: ~~09/27/12~~

APPROVED:

Board Of Directors: ~~09/26/12~~

(10) Administration
General:
Identification of and Disposal of Excess Hospital Equipment and/or Supplies
10-1079

6. The Finance Department shall remove the approved disposal items from inventory or fixed asset listing.

7. Disposal of expired supplies. The departments with expired supplies shall either notify Materials Management for pick up or bring the items to the Materials Management Department for disposal in accordance with accepted practices. If you are waiting for Materials Management to pick up the supplies, be sure to segregate the supplies, to ensure that they are not mistakenly put back in service and clearly mark them as expired items.

   A. Recognition of expired supplies

      1. Packages can be marked in several different ways to indicate expiration dates.

         a. Markings may have an hour glass with the bottom half filled. Next to this symbol it may have a 2 digit month and a 2 or 4 digit year. Possibly could have a 2 digit day of the month.

Symbol for "Use By". This symbol shall be adjacent to the expiration date.

         b. Markings will say "EXP" or "Expires" followed by a 2 digit month and a 2 or 4 digit year. Possibly could have a 2 digit day of the month

         c. Packages could be marked with a symbol that looks similar to a building that has 2 or 3 peaks with a smoke stack; this is a manufacture date and does not represent or imply an expired item.

Symbol for "Manufacturer". The symbol shall be adjacent to the date that the product was manufactured,

         d. Packages may be labeled "Package guaranteed sterile unless opened or damaged", in this case use your best judgment as to the condition of the package.

         e. If there is a 2 digit month and a 2 or 4 digit year with no other explanation, this usually represents a manufacture date.

         f. All expired medications and/or drugs shall be disposed of in accordance to Pharmacy policies.

All monies collected from disposed items shall be immediately forwarded to the Finance Department for deposit into the hospital general fund. Hospital employees who offer and employees who receive hospital assets, such as equipment and/or supplies being disposed

of without proper authorization may be subject to disciplinary action, including immediate termination without notice.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Identification of and Disposal of Excess Hospital Equipment and/or Supplies
Descriptive Type:	Revised
Document Number:	10-1079
Attachments:	None
Author:	~~Ron Nelson~~Celeste Terronez, Director, Materials Management
Typist:	Ron Nelson/Gillian Busch
Creation Date:	04/13/12
Revision Date:	1/17/18
Prev. Dist. Date:	01/01/07

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Comm. (EOC)	~~08/30/12~~	
Board of Directors	~~09/26/12~~	

Effective Date:	09/27/12
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Customer Service Standards

I. Introduction:

All Tulare Regional Medical Center (TRMC) employees will follow the Standards of Customer Service, which are aligned with the Tulare Regional Medical Center's Customer Service Value of providing *compassionate, courteous, respectful and dignified care, while maintaining confidentiality and sensitivity to every individual*, whether an internal or external customer.

The Tulare Regional Medical Center culture of excellent service is the outcome of the mandatory TRMC **Achieving Excellence:** *You Make a Difference* Customer Service Program.

II. Standards:

The following are staff behaviors and expectations which will be applied for all customers, during every encounter.

1. Greet:

    - Make eye contact
    - Smile
    - Introduce self with friendly attitude (*sincere and confident*)
    - Engage the customer (*call them by name; speak to the customers level)*
    - Professional dress (adhere to *Dress and Personal Appearance HR standard)*

2. Value:

    - Give your undivided attention

- Show empathy
- Acknowledge their opinions
- Personalize their needs
- Be respectful (*tolerant of cultural differences*)

3. Ask:

    - Ask open-ended questions
    - Use positive body language

4. Listen:

    - Actively listen (*don't assume!)*
    - Focus on the person (*be there for them!)*
    - Be mindful of customers body language
    - Non-defensive attitude
    - Clarify the conversation
    - Listen to how they "feel" (*i.e., words and tone of voice*)

5. Help:

    - Satisfy their wants and needs
    - Involve them in the process
    - Take them to the location they seek
    - Be willing to go beyond your job description
    - Give them more than what they ask for
    - Follow up and keep your word

6. Invite:

    - Ask if there is anything else you can do for them
    - Thank them for using Tulare Regional Medical Center
    - Make them feel appreciated
    - Leave them with a great feeling

III. TRMC Department Specific Standards:

Each department at TRMC will follow the established Customer Service Standards in addition to creating standards specific for their department. These department standards will guide daily practice and augment the existing TRMC Customer Service Standards**.**

IV. Staff and Leader Accountability:

All Tulare Regional Medical Center staff will abide by the Customer Service Standards at all times.

A. All employees will complete the **Achieving Excellence**: *You Make a Difference* Customer Service Program.

B. All employees will attend refreshers and updates in Customer Service as requested.

C. All leaders role model the standards, support the program and hold staff accountable for following the Customer Service Standards.

D. When the Standards are not met, leaders will implement corrective action **ASAP** (including coaching and documentation) according to the *Disciplinary Action* HR standards.

V. Performance Appraisals:

Customer Service employee behaviors will be documented on the Employee Performance Appraisal. If the Standards are not met, a Development Plan will be initiated.
Leaders will evaluate contract employees in the same manner, utilizing the contract organization's performance appraisal which will uphold and support the Tulare Regional Medical Center Customer Service Standards.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Customer Service Standards

Descriptive Type: Revision

Document Number: 10-1087

Attachments: None

Author: Carol Bradford

Typist: Carol Bradford

Creation Date: 01/04/07

Revision Date: 01/10/18

Prev. Dist. Date: 09/28/12

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : All Departments

FROM : Administration

SUBJECT: Membership to Trade and/or Professional Associations

Tulare Local Health Care District ~~Hospital~~ Directors/Managers are encouraged to participate in respective professional, and community service associations, boards, and commissions, that promote personal professional and/or institutional development and enhancement. Such involvement is endorsed by the Administration. Such participation may or may not be considered for "hours worked" and some expenses may be reimbursed. Permission for such may be granted by the CEO. The CEO will consider reimbursement based on best interest of the hospital.

Administration is responsible for approval of District sponsored memberships, and department directors must recommend interested employees for such District sponsored memberships. The District may pay for or reimburse a limited number of memberships in designated professional associations.

Department Directors must plan, approve, and budget for employee membership and attendance at all approved professional or community association board or commission meetings, seminars, and conventions. The District~~Hospital~~ will pay and/or reimburse employees for registration fees and reasonable expenses to attend such functions when approved following the guidelines set forth in hospital policies 10-1031.1 and 10-1031.2.

Employees are encouraged to contribute articles, present papers, and give talks to professional associations and to association publications. Employees must obtain the prior approval before submitting any communication that might be considered as representing ~~Tulare~~ District ~~Hospital~~ position on any subject or may involve any confidential information.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Descriptive Name:	Membership to Community and/or Professional Associations
Descriptive Type:	Revised
Document Number:	10-1090
Attachments:	None
Author:	~~Paula Richards~~/Paula Richards/Andrea Carrasco/Ena Menezes
Typist:	~~Julie Gresham~~Carol Bradford
Creation Date:	11/29/02
Revision Date:	02/01/18
Prev. Dist. Date:	12/11/02

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/03/07~~	

Effective Date:	~~01/04/07~~
Forward To:	Policy Binders – Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments, Medical Staff, and Tulare Association of Churches (TAC)

FROM: Administration

SUBJECT: TLHD Chaplaincy Program (Partners In Healing) (HIPAA)

Tulare Local Health Care District in conjunction with the Tulare Association of Churches (TAC) hereby establishes a TLDH Interfaith Chaplaincy Services Program to accommodate the right of patients to pastoral and other spiritual services.

INTRODUCTION:

Ministry to the spiritual needs of patients plays an essential role in their healing process. While patients may be reassured by ministration from nurses, physicians, and other personnel who tend their ailments in the hospital, patients may also seek the help of a pastor or other representative of a church or religious faith to tend to their spiritual needs.
The clergy, administration, and staff associated with Tulare Local Health Care District recognize the right to pastoral and other spiritual services for patients at Tulare Local Health Care District.
In the provision of health care, each of the professions play a unique role that involves both privileges and disciplines. Each agrees to abide by standards herein set forth in harmony with the total team.

OBJECTIVES:

1. To make a religious ministry regularly available with trained persons, with time to share with all patients in conformance with their faith and an expressed desire for such a ministry; to increase the well-being of these patients; to speed their recovery.

2. To incorporate, consistent with patient preference, the ministry efforts of local churches and religious leaders within the health team.

3. To afford an opportunity for all the religious groups in the community to provide pastoral and other spiritual services for Tulare Local Health Care District patients.

4. To provide for ministry to the whole person to meet spiritual needs, emotional needs, and assist with ethical questions.

HOSPITAL PROCEDURES:

1. ~~A hospital census print-out shall be maintained at the information desk. The Auxiliary are at this desk from 8:30 a.m. to 8:00 p.m., Monday through Saturday. On Sundays, it may be necessary to contact the Switchboard Operator in PBX next door to the Information Desk. The census print-out shall be available only to those ministers and other professional religious leaders registered as participating clergy.~~ The hospital staff can disclose to a member of the clergy from the ~~hospital~~ directory:

   a. the patient's name;

   b. the patient's general condition in terms that do not communicate specific medical information about the patient;

   c. the patient's location in the facility; and

   d. the patient's religious affiliation.

   A disclosure of directory information may be made to members of the clergy even if they do not inquire about a patient by name.

   The patient has the right to exclude their religious affiliation from the patient registry as well as any of the other elements mentioned above.

2. Not more than two (2) clergy members will be registered from any one religious group at a time, except by special arrangements with Administration~~the Hospital Chaplain~~. Only registered clergy members shall be given information pertaining to patients who may want a visit. ~~access to the patient census or be accorded other privileges reserved for such persons.~~ Lay persons, recommended by their pastor, and trained by chaplain, may assist chaplain. They will carry a badge/ID.

3. Each registered clergy member shall be identified with a "Clergy" badge which (s)he will wear while visiting patients in the hospital. (S)he may, of course, visit without the badge, in which case (s)he shall follow the same standards as all other visitors.

4. The clergy member, while serving in a professional capacity, will confine calls to those patients who are affiliated with his/her church and/or who have requested his/her services. The clergy member is encouraged to consider the patient's well-being and regulate frequency and length of visits accordingly.

5. The clergy member shall be given access to isolation rooms or the Intensive Care Unit only after speaking with the attending physician and/or the patients~~supervisory~~ nurse.

6. In those cases where "No Visitors" or "Family Only" is indicated on the patient census, the minister may contact the family and/or the supervisory nurse to determine if their visit is appropriate.

7. Nursing personnel shall respect the clergy member's need for privacy with his/her parishioner; ministrations will be interrupted only where necessitated by the patient's condition.

8. In a cooperative effort to perform a meaningful ministry as a member of the healing team, the clergy member will observe the following:

   a. (S)he will be supportive of the doctors and the nursing personnel at all times, and (s)he will seek to keep his/her activities within the hospital in harmony with these established principles, policies, and procedures. If (s)he feels the need to discuss matters related to the patient's treatment, (s)he will do so with the responsible health care person.

   b. (S)he will see that prayer with patients/families is private and is quietly expressed and calming.

   c. (S)he will administer the sacraments in such a way that (s)he will not disturb other patients or the hospital routine.

   d. (S)he will conduct such matters as death-bed conversions and confessions with the utmost discretion and only when such ministrations are clearly justified by the conditions.

   e. (S)he will see him/herself as an essential part of the healing team, working in harmony with the doctors, the nursing personnel, hospital administration, and fellow ministers.

ROLE OF THE HOSPITAL CHAPLAIN:

1. In cooperation with the Tulare Association of Churches, Tulare Local Health Care District shall select a qualified person to serve as the Hospital Chaplain.

2. The Hospital Chaplain will represent the clergy to the Hospital Board and/or Administration.

3. When the Hospital Chaplain is not available, alternate plans or persons will be arranged by the Hospital Chaplain to provide continuation of ministry services needed during his/her absence.

RESPONSIBILITIES OF THE HOSPITAL CHAPLAIN:

1. Make regular rounds and respond to referrals from nurses, physicians, social ~~worker~~services, etc.

2. Visit with patients who desire a chaplain visit ~~and document the visit and anything pertinent in the patient's chart~~.

3. Be on call for emergency situations.

4. Through friendly, tactful inquiry determine if the patient desires spiritual assistance in helping to meet the patient's social, emotional and spiritual needs with regard to their health condition. When the need is indicated, the Chaplain will contact the patient's minister of choice. Refrain from diagnosing prognosticating vis-à-vis the patient's illness.

5. Help patient and family deal with faith challenges that come in the health crisis and hospitalization.

6. The Chaplain will provide a similar supportive role to the family and close friends of the patient when appropriate. Help heal their spiritual and emotional condition to assist patient back to good health. Deal with issues of illness and separation.

7. The Chaplain, or any appropriate minister, will be called for those times in which a physician, hospital employee, patient or relative feels their services are needed.

8. In conjunction with the health care team, assist patients to face and deal with serious health decisions.

9. Ensure spiritual and personal values, beliefs and preferences are respected.

10. Establish and maintain active working relationships and cooperation with community pastors. Chaplain will supplement the role of the regular clergy person for those already related to a local congregation.

11. Work in cooperation with hospital staff, department managers, related agencies, etc. Attend and participate in appropriate medical staff meetings.

12. The chaplain will serve as a member of the district~~hospital~~ ethics committee.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: TLHD Chaplaincy Program (Partners In Healing) (HIPAA)

Descriptive Type: Revised

Document Number: 10-1092

Attachments: None

Author: Philipina Menezes and Andrea Carrasco~~Helmut Busch~~

Typist: ~~Hillary Keith~~Carol Bradford

Creation Date: 11/08/06

Revision Date: 01/08/18

Prev. Dist. Date: 113/~~32~~0/0~~66~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~11/19/08~~	

Effective Date: ~~11/20/08~~

Forward To: Policy Binders = 5 and post on Intranet site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Grievance Procedure for Persons with Disabilities (Non-Employee)

Policy:

It is the policy of Tulare Regional Medical Center not to discriminate on the basis of disability. Tulare Regional Medical Center has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act. Section 504 states, in part, that "no otherwise qualified handicapped individual...shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The Law and Regulations may be examined in the Human Resources office of John Barbadian, V.P. of Human Resources, 559.688.0821 who has been designated to coordinate the efforts of Tulare Regional Medical Center to comply with Section 504.

Any person who believes she or he has been subjected to discrimination on the basis of disability may file a grievance under this procedure. It is against the law for Tulare Regional Medical Center to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

Procedure:

Grievances must be submitted to the Section 504 Coordinator within 72 hours of the date the person filing the grievance becomes aware of the alleged discriminatory action.

A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

The Section 504 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records of Tulare Regional Medical Center relating to such grievances.

Effective Date: ~~05/27/10~~	(10)	Administration General: Grievance Procedure for Persons With Disabilities (Non-Employee) Procedure 10-1098
Approved: Board of Directors: ~~05/26/10~~		

The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the Chief Executive Officer within 15 days of receiving the Section 504 Coordinator's decision.

The Chief Executive Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination on the basis of disability with the U. S. Department of Health and Human Services, Office for Civil Rights.

Tulare Regional Medical Center will make appropriate arrangements to ensure that disabled persons are provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for such arrangements.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Grievance Procedure for Persons with Disabilities (Non-Employee)
Descriptive Type:	Revised
Document Number:	10-1098
Attachments:	None
Author:	Julie Gresham
Typist:	Julie Gresham
Creation Date:	05/05/10
Revised Date:	4/24/18
Prev. Dist. Date:	12/29/05

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~05/26/10~~	

Effective Date:	~~05/27/10~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	Revisions as required by the Department of Health and Human Services, Office for Civil Rights, Washington DC.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Interference with Access to Health Care

I. PURPOSE:

This policy is established to safeguard and protect patients, physicians, employees, volunteers and visitors from intentionally being prevented from entering or leaving hospital property and buildings.

II. POLICY:

A. In accordance with Title 6 of Part I of Division 4 of the California Civil Code, it is unlawful to intentionally prevent an individual from entering or exiting a health care facility by physically obstructing the individual's passage or by disrupting the normal functioning of a health care facility.

B. Disrupting the normal function of this health care facility means intentionally rendering or attempting to render this health care facility temporarily or permanently unavailable or unusable by physicians, employees or patients.

C. Such disruption does not include acts of the owner, an agent of the owner (CEO or designee) or officers or employees of a governmental agency acting to protect the public health or safety.

D. A person acting alone or in concert with others will not be allowed to intentionally prevent an individual from entering Tulare Local Health Care District or hospital property by physically obstructing the individual's passage or by disrupting the normal functioning of the hospital.

E. A person or hospital aggrieved by these unlawful actions may seek civil damages from those who committed the prohibited acts and those acting in concert with them.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: ~~02/24/11~~

Approved:

Medical Executive Comm.: ~~02/09/11~~

Board of Directors: ~~02/23/11~~

(10) Administration
General:
Interference with Access to Health Care
10-1106.5

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Interference with Access to Health Care

Descriptive Type: Revised

Document Number: 10-1106.5

Attachments: None

Author: Johnny Lopez (~~On-Site~~Contracted Security)

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 02/10/06

Revision Date: 02/01/18

Prev. Dist. Date: 04/23/06

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	~~01/31/11~~	
MEC	~~02/09/11~~	
Board of Directors	~~02/23/11~~	

Effective Date: ~~02/24/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff and All Departments

FROM: Administration

SUBJECT: Risk Management Plan

I. **PURPOSE:** To reduce or eliminate risk of injury or loss as well as to protect the hospital's financial resources through maintaining a high quality of patient care within the resources available to the hospital and by maintaining a safe and secure hospital environment.

II. **POLICY:** The Risk Management Program is hospital wide in scope and requires participation from all employees and health care providers in the reporting and remedy of potentially harmful conditions or behavior. The Risk Management Program will be based upon the Risk Management Process: 1) identification of risk, 2) notification of risk, 3) analysis of those potential risks, 4) treatment of potential risks, 5) evaluation of the risk management process and any plans or actions.

III. **AUTHORITY:** The Board of Directors has overall responsibility and authority for the establishment and support of the Risk Management Program. The Board delegates authority and responsibility to Hospital Administration and Medical Staff for development of a hospital wide Risk Management Program. Administration delegates the implementation, coordination, maintenance and evaluation of the Risk Management Program to the Director of Risk Management.

IV. **PROGRAM GOALS:**

A. To establish and monitor the systems designed to detect, evaluate and correct problems in the delivery and documentation of patient care. To provide operational linkages to the Performance Improvement functions within the organization.

B. To detect and remove hazards in the physical environment which have potential to cause harm.

C. To identify potentially compensable events on a prospective, concurrent, and retrospective basis.

D. To mitigate and control claims against the facility once an undesirable event has been detected and to assist the hospital attorney in the gathering and interpretation of information pertinent to claims.

E. To limit, reverse or minimize the potential or actual negative effects of an undesirable event through concurrent and proactive actions.

F. To evaluate all aspects of the Risk Management Program yearly and make recommendations and modifications as needed to assure program goals are met as efficiently as possible.

G. To meet the standards and regulations governing health care organizations as prescribed by federal, state and local agencies, and voluntary accrediting programs.

V. RESPONSIBILITIES:

A. BOARD OF DIRECTORS:

1. The Board of Directors shall have the ultimate authority and responsibility for a flexible, comprehensive and integrated Risk Management Program.

2. The Board of Directors authorizes Administration and the Medical Staff to designate personnel to implement the Risk Management Program.

3. The Board of Directors shall make the commitment to provide necessary resources to allow Administration to provide the specific services, equipment, and personnel required to support the Risk Management Program.

B. ADMINISTRATION:

The Administrator shall require all clinical services and ancillary departments, their directors, managers, and employees (including contracted employees) to participate in the Risk Management Program.

C. MEDICAL STAFF:

1. The Medical Staff, through its officers and various committees, participates and assists in risk management activities, recommends interventions and evaluates outcomes of interventions taken as appropriate.

2. Issues or trends identified through the Risk Management program are brought to the appropriate committee for consideration and action.

D. **DIRECTOR OF RISK MANAGEMENT:**

The Director of Risk Management shall implement, evaluate and maintain the effectiveness of the risk management activities. The Director of Risk Management activities include:

1. Coordination of the planning, organizing, implementation and monitoring the effectiveness of the Risk Management Program.

2. Annual report to the Board of Directors addressing risk management issues and outcomes.

3. Coordinate and assist in providing risk management education for the organization.

4. Attends organizational, Medical Staff and Board of Directors meetings to present and discuss risk management issues as appropriate.

VI. **CONFIDENTIALITY:**

All Risk Management incident occurrence reporting information is collected under the direction of the Director of Risk Management, who reports to the Performance Improvement Committee in the interest of sustaining and improving the quality of care provided by Tulare Local Health Care District. Occurrence reporting is protected from discovery under the California Evidence Code Section 1157 and in cases of Administration attention the attorney client privilege.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Descriptive Name: Risk Management Plan

Descriptive Type: Revised

Document Number: 10-1109

Attachments: None

Author: Julie Gresham

Typist: Julie Gresham/Andrea Carrasco/Ena Menezes

Creation Date: 01/20/14

Revision Date: 02/05/18

Prev. Dist. Date: 7/24/03

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~02/26/14~~	

Effective Date: ~~02/27/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Ethics Committee

The TLHD~~H~~ Ethics Committee is established:

1. To assist and facilitate the sharing of information on medical ethical issues and to act as a resource for the resolution of conflicts in care or treatment decisions;

2. To provide an advisory forum for hospital and medical professionals, patient/family, and others to discuss medical issues;

3. To act as a resource for persons involved in medical decision making;

4. To support patients' rights as related to treatment and services with regard to their social, cultural, and religious needs; and

5. To educate staff regarding the process for referring ethical issues.

The committee does not serve as a review board of professional ethics, as a substitute for legal or judicial review, nor as a decision making body in ethical dilemmas. When the committee acts as a forum to discuss ethical issues involved in patient care, it does not act as a replacement for existing personnel within the hospital who are the primary and first line resources in handling ethical issues.

It is also important to note that the Ethics Committee is not a substitute for the physicians, nurses, family members and affected patients who are the traditional and rightful decision-makers in questions of medical treatment. The committee's goal is to illuminate and discuss all available treatment options and their consequences, and to assist professionals, families and patients in making decisions when they are faced with dilemmas.

Procedure:

1. See attached information regarding "Do you have an Ethical Concern"?

Effective Date: ~~05/24/07~~ (10) Administration General: Ethics Committee 10-1110

APPROVED:

2. Complete attached form “Ethical Concern Form”.

3. Send completed form to Administration.

Meetings

The Ethics Committee is composed of district~~hospital~~ employees representing various healthcare disciplines, clergy, physicians, and other members deemed appropriate by the chair and/or Ethics Committee. The committee meets as requested during regular business hours to hear any pertinent case. Once asked to convene, the committee strives to come together within 48 hours or sooner if the case dictates. Access to the committee is open to all individuals involved in patient care decisions at Tulare Regional Medical Center~~District Hospital~~. (See attached flow chart.)

The Ethics Committee will meet at least annually to evaluate any issues that have been presented through the year. The Committee will review goals, effectiveness of committee actions, and policies pertaining to ethical issues at the annual meeting. Core membership on the committee is composed of the appointed medical staff member, a representative from Patient and Family Services who is the Chairperson for the Committee, Risk Management, Case Management, Nursing, Administration, Clergy, and outside resources as deemed appropriate.

For more information on the Tulare Local Health Care District ~~Hospital~~ Ethics Committee, please contact the Ethics Chairman and/or Administration.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

DO YOU HAVE AN ETHICAL CONCERN?

Occasionally while receiving or providing medical care to people, ethical dilemmas arise.

What is an ethical dilemma?
The following are areas that may present ethical conflicts:

1. Questions of competency of a person or persons making medical decisions (patient, family, medical professions, etc.)

2. Concerns regarding current treatment being given.

3. When there are questions or concerns regarding cultural, social, religious or spiritual needs.

4. When there are questions or concerns regarding physical and/or medical treatment.

5. When there are questions or concerns regarding treatment to prolong life.

What can be done about an ethical dilemma?
Tulare Local Health Care District ~~Hospital~~ has an Ethics Committee. This committee is assembled when ethical issues are brought to the attention of Administration. This committee acts to:

1. Facilitate a plan of resolution.

2. Serve as a forum for hospital/medical professionals, patient, family, and others.

3. Act as resource in medical decision-making.

How do I notify Administration of an ethical dilemma?
You can verbally report your concern to Administration or you can complete and return the attached form (Ethical Concern) to Administration.

Do I have to be directly involved if I report an ethical dilemma?
No. You do not have to include your name on the form or you can ask Administration to keep your identification confidential.

Who can notify Administration of an ethical dilemma?
Anyone can notify Administration of their concerns. This includes patients, family members, guardians, employees, physicians, etc.

ETHICAL CONCERN FORM

DATE:_____**YOUR NAME (**optional**):**_____

PATIENT NAME:_____**MEDICAL RECORD #**_____

PATIENT PHYSICIAN:_____

PATIENT'S MEDICAL DIAGNOSIS (Why are they in the hospital)**:**

_____

_____

WHO ARE THE INVOLVED PARTIES IN THIS SITUATION?:

_____

WHAT IS CURRENTLY BEING DONE? (Medical treatment, discharge planning, financial planning, etc.)**:**

_____

_____

_____

_____

_____

WHAT IS YOUR ETHICAL CONCERN ABOUT THIS SITUATION?:

_____

_____

_____

_____

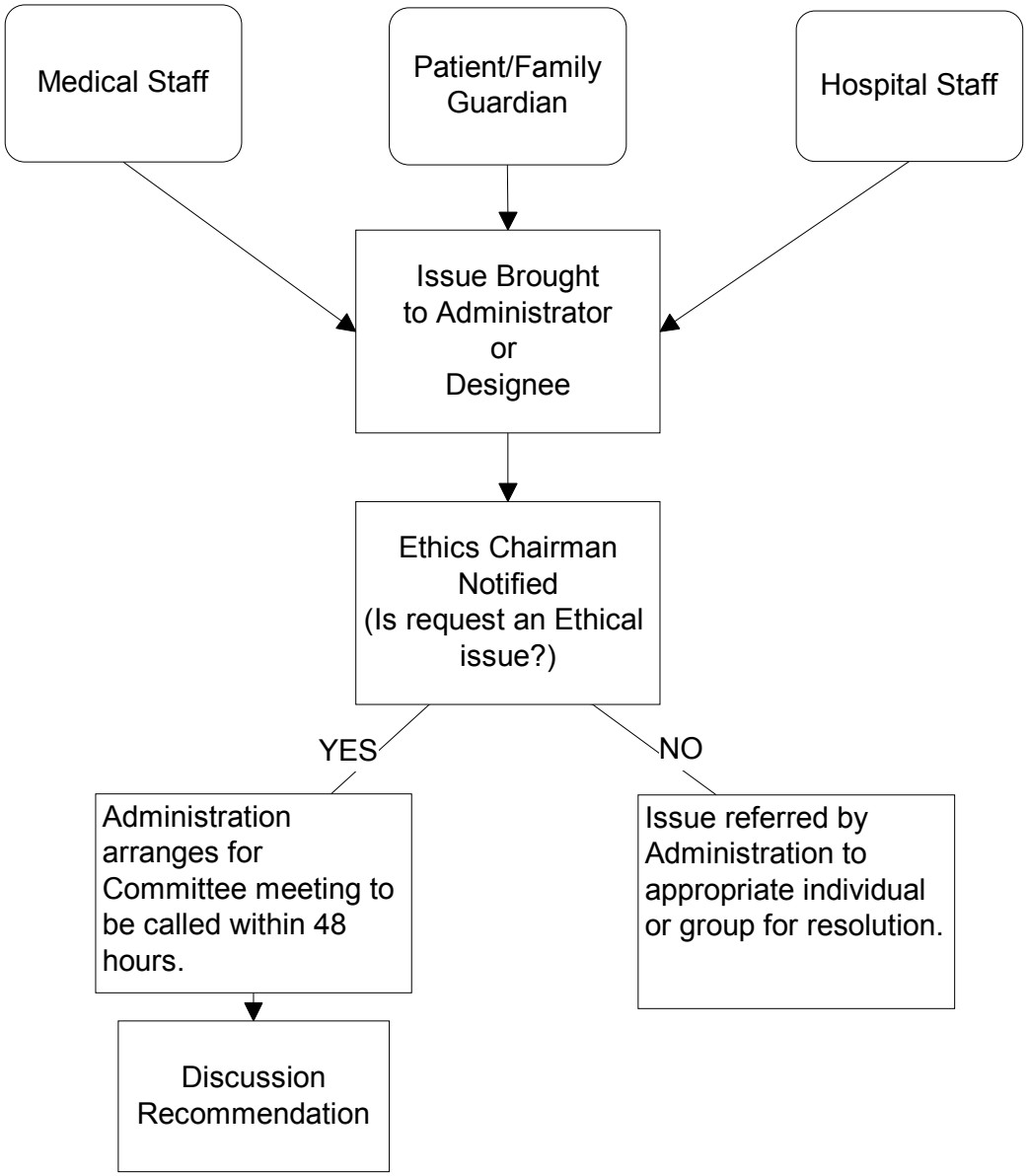
COMMITTEE CHAIR:

- **Reviewed and referred to Ethics Committee**

Deferred:_____

Comments_____

Ethics Committee



Descriptive Name: Ethics Committee

Descriptive Type: Revised

Document Number: 10-1110

Attachments: "Do You Have An Ethical Concern?" resource sheet and Ethical Concern Form

Author: Philipina Menezes and Andrea Carrasco~~Ruben Rojas~~

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 05/05/06

Revision Date: 01/05/18

Prev. Dist. Date: 12/29/05

Committee Review and Approval:	Approval Date:	Comments:
PI Committee	~~3/22/07~~	
MEC	~~5/9/07~~	
Board of Directors	~~5/23/07~~	

Effective Date: ~~05/24/07~~

Forward To: Policy Binders – ~~5 and~~ post to Intranet site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Use of Protected Health Information (PHI) in Marketing (HIPAA)

I. Purpose

To define the staff usage of protected health information (PHI) in marketing and to outline staff responsibility in creating and providing access to properly de-identified data as provided under the Health Insurance Portability and Accountability Act (HIPAA).

II. Use of Protected Health Information in Marketing

A. Marketing means:

1. To make a communication about a product or service that encourages recipients of the communication to purchase or use the product or service, unless the communication is made:

   a. To describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the hospital, including communications about: the hospitals participation in any health care provider network or health plan network; replacement of, or enhancements to, a health plan; and health-related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits.

   b. For treatment of the individual; or

   c. For case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or settings of care to the individual.

2. An arrangement between the hospital and any other entity whereby the hospital discloses protected health information to the other entity, in exchange for direct or indirect remuneration, for the other entity or

its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service."

3. The hospital staff must obtain the patient's authorization before making uses or disclosures of protected health information (PHI) for marketing.

4. The staff is permitted to use and disclose PHI for certain marketing activities without patient authorization under the following circumstances:

   a. The hospital staff can use or disclose PHI without patient authorization for a marketing communication, if the communication occurs in a face-to-face encounter with the patient.

   b. The hospital staff can also use or disclose PHI without patient authorization for a marketing communication involving products or services of only nominal value used to promote the hospital.

B. "Any marketing communication from the hospital about the health-related products or services of the hospital must identify the hospital as the source of the communication. The hospital may not send out any information about the product of any third-party unless the communication identifies the third-party source of that communication. If the hospital receives any direct or indirect remuneration for the marketing communication, the marketing communication must prominently state that fact."

C. The hospital must also include in their communication (unless it is a general similar device) how the patient may prevent further communications about health-related products and services.

D. When the hospital staff targets communications to patients on the basis of their health status or condition, the staff must make a determination that the product or service being communicated may be beneficial to the health of the type of patients targeted, and that communication to the targeted patients explains why they have been targeted and how the product or service relates to their health.

E. The hospital is restricted to uses or disclosures to their business associates pursuant to a contract that requires confidentiality, ensuring that PHI is not distributed to third parties.

III. Creation and Uses of De-identified Information

A. The staff is permitted to use PHI to create de-identified information, whether or not the de-identified information is to be used by the hospital.

B. To use de-identified information, the hospital staff must document the methodology used to de-identify it.

C. The staff must remove all elements of a patient record designated as patient identifiers by the HIPAA regulations._

D. The following identifiers of the individual or of relatives, employers, or household members of the individual, are removed:

a. Names

b. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

1. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

2. The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people are changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

4. Telephone numbers;

5. Fax numbers;

6. Electronic mail addresses;

7. Social security numbers;

8. Medical record numbers;

9. Health plan beneficiary numbers;

10. Account numbers;

11. Certificate/license numbers;

12. Vehicle identifiers and serial numbers, including license plate numbers;

13. Device identifiers and serial numbers;

14. Web Universal Resource Locators (URLs);

15. Internet Protocol (IP) address numbers;

16. Biometric identifiers, including finger and voice prints;

17. Full face photographic images and any comparable images;

18. and any other unique identifying number, characteristic, or code, except as permitted by paragraph (3) of this section."

E. Methodologies used to de-identify information must be approved by the Privacy Officer prior to disclosure as described by law and hospital policy.

F. The staff must have no actual knowledge that the information could be used alone or in combination with other information to identify a patient. Disclosure of a key or mechanism that could be used to re-identify such information is also a disclosure of PHI and is not permitted.

G. All dates directly related to the patient must be removed or limited to the year, and zip codes must be removed or aggregated as described in the HIPAA regulations.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Use of Protected Health Information (PHI) in Marketing (HIPAA)
Descriptive Type:	Revised
Document Number:	10-1112
Attachments:	None
Author:	LuAnn Perry
Typist:	Julie Gresham/Andrea Carrasco/Ena Menezes
Creation Date:	11/15/10
Revision Date:	02/13/18
Prev. Dist. Date:	3/24/05

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/26/11~~	

Effective Date:	~~01/27/11~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	
HIPAA Compliance:	164.514(e) 164.514 (a-c)

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff and Emergency Department

FROM: Administration

SUBJECT: Physicians' On-Call Roster for the Emergency Department

To comply with the Medical Staff Bylaws, Rules and Regulations, Title 22 and COBRA guidelines, the following policy is established for the physician on-call for the Emergency Department.

1. The following specialties will be listed on the monthly roster:
   - Primary Emergency Backup – 1 or more days as assigned.
   - OB-GYN – rotation as designated by the physicians.
   - Surgery – as designated by the surgeons.
   - Orthopedics – as designated by the Orthopedists.
   - Pediatrics – rotation by the Pediatricians.
   - Cardiology

Specialists on the On-Call Roster will be available for consultation for patients who must be admitted first under the care of the primary care physician.

Only physicians/surgeons who have privileges will be allowed on the On-Call Roster. Practitioners whose privileges are suspended, restricted, are being monitored or proctored may not serve on the call panel. Exceptions may be made by Medical Executive Committee.

The Medical Staff Office will be responsible for scheduling the above services as directed.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~05/26/11~~ (10) Administration
General:

APPROVED: Physicians' On-Call Roster for the Emergency Department

Medical Executive Comm.: ~~01/12/11~~ 10-1115

Board Of Directors: ~~01/25/11~~

Descriptive Name: Physicians' On-Call Roster for the Emergency Department

Descriptive Type: Revised

Document Number: 10-1115

Attachments: None

Author: Marilyn Randon

Typist: Julie Gresham/Gillian Busch

Creation Date: 08/09/10

Revised Date: 4/24/18

Prev. Dist. Date: 09/25/08

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~01/12/11~~n/a	Date change only
Board of Directors	~~05/25/11~~	

Effective Date: ~~05/26/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Medical Staff

FROM: Administration

SUBJECT: Program BETA Peer Review Network

BACKGROUND

Tulare District Hospital is a participant in Program BETA's Peer Review Network. As a member of this network, TDH Medical Executive Committee may contact any other member in the network to request assistance in the performance of peer review activities by TDH Medical Staff. The existence of this policy does not obligate TDH Hospital Medical Staff to utilize the network unless it is the decision of TDH Medical Executive Committee that it is in the best interests of the hospital to do so.

POLICY

It is the policy of Tulare District Hospital that whenever the Medical Executive Committee, in conjunction with the Administrator, determines that review of a case by a health care practitioner outside of TDH Medical Staff would assist in the evaluation of medical care provided at TDH, such outside review may be sought. The TDH Medical Executive Committee is encouraged to utilize the physicians and other health care providers within the Peer Review Network when a decision is made to seek outside review of any case.

PROCEDURE

When a decision is made by TDH Medical Executive Committee to utilize an outside consultant within the Program BETA Peer Review Network, the Chief of Staff, or his or her designee, shall proceed as follows:

A. **SELECTION OF THE OUTSIDE CONSULTANT**

The Peer Review Network hospital to which the review request will be directed should be selected.

Contact should be made with the Chief of Staff of the selected hospital to request a referral of the name of a physician on their medical staff who may be willing to perform the review.

The referring Chief of Staff should be asked to select a physician (or other appropriate provider if the case involves a dentist, podiatrist, or allied health practitioner) who is:

1. In good standing on their medical staff;

2. Board Certified and practicing in the specialty of the practitioner under review;

3. Someone who has shown a commitment to peer review and to high quality patient care; and

4. Someone who is willing to be both objective and critical.

The consultant suggested by the referring Chief of Staff should then be contacted to request that he or she serve as a consultant to TDH Medical Executive Committee.

B. **APPOINTMENT AS CONSULTANT TO THE MEDICAL EXECUTIVE COMMITTEE**

Once the practitioner has accepted, he or she should be appointed as a consultant to TDH Medical Executive Committee.

C. **COMMUNICATION WITH THE CONSULTANT**

The TDH Chief of Staff shall write a letter confirming the appointment of the consultant as a consultant to the TDH Medical Staff. This letter shall contain:

1. A statement that the consultant is being asked to critically evaluate whether the care provided by the practitioner under review fell below the standard of care in the general medical community.

2. A request that the consultant prepare a written report directed to the TDH Chief of Staff.

3. A reminder that the consultant's activities and opinions are strictly confidential.

4. A description of the compensation, if any, that is to be provided to the consultant.

D. **WHAT TO PROVIDE THE CONSULTANT**

Along with the letter from the Chief of Staff, the consultant should be provided with:

1. A list of the chart(s) to be reviewed and the specific concerns identified about each chart.

2. A copy of the complete chart(s), if possible, with the patient name (but not the medical record number) removed from each page.

E. **REPORT OF OUTSIDE CONSULTANT**

The report of the outside consultant is a confidential record of the Medical Executive Committee. It may be disclosed to the Board of Trustees if requested by a board member, to medical staff committee members who have a need to review it, to the hospital Chief Executive Officer, to the hospital's legal counsel, and to the hospital Risk Manager. No further disclosures may be made without approval of the Chief of Staff and the hospital Chief Executive Officer.

When there is any doubt as to whether a person should be permitted access to the report, the hospital's legal counsel and/or Risk Manager should be contacted prior to releasing the information.

The practitioner under review shall not be permitted access to the consultant's report without prior approval of the Chief of Staff and the hospital Chief Executive Officer.

F. **COMPENSATION OF THE CONSULTANT**

It is the policy of TDH to determine the appropriate compensation for the consultant on an individual basis. The decision involves consideration of the amount of time involved in the review, the complexities of the cases, and the consultant's expertise. All compensation decisions must be approved by the Chief Executive Officer.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces or supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Program BETA Peer Review Network

Descriptive Type: Revised

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Author: Denise Perry/Robert Montion

Typist: Julie Gresham

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MEC	n/a	Date change only
Board of Directors		

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Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Securing Patient Monies/Valuables and Property Damage or Loss

PURPOSE

The purpose of this policy is to describe the processes that staff will follow to properly document, store, secure and release patient monies and valuables while admitted to Tulare Regional Medical Center. This policy also describes the limits on the hospital's liability in the event patient monies or valuables are lost or damaged while admitted to Tulare Regional Medical Center.

NOTICE TO PATIENTS AND THEIR REPRESENTATIVES

A. During the admitting process, each and every patient (or patient's responsible party) shall be personally notified, in writing, of each of the following:

1. The hospital keeps a fireproof safe and shall not be liable for the loss or damage to any patient money, jewelry, documents, furs, or other articles of unusual value and small size, unless deposited with the hospital for safekeeping;

2. Patients should keep in their rooms only those personal items necessary for their own safety and comfort during their hospital stay ("essential personal items"). Examples of such items include eye glasses, dentures, and hearing aids;

3. Any non-essential personal items should be sent home, whenever possible. Examples of such items include iPods, cellular telephones, and Palm Pilots;

4. In the event any patient monies or valuables placed with the hospital for safekeeping are damaged or lost due to the hospital's own acts or omissions, the hospital's liability is limited by statute to five hundred dollars ($500.00), unless a written receipt for a greater amount has been obtained from the hospital by the patient.
5. In the event a patient's essential personal items not deposited with the hospital for safekeeping are damaged or lost due to the hospital's own acts or omissions, the hospital's liability for such items shall not exceed five hundred dollars

($500.00), unless a written receipt for a greater amount has been obtained from the hospital by the patient.

6. The hospital shall not be liable for any damage or loss of patients' non-essential personal items.

PROCEDURE

A. General Admits:

1. All patient property will be inventoried on a Patient Property List form in the electronic medical record at the time of admission. The admitting Registered Nurse, LVN, or CNA is responsible for accurately completing the Patient Property List form in the electronic medical record.

2. Any patient or responsible party for the patient may request to have his or her valuables locked in the hospital safe, or otherwise secured for safekeeping. Such items shall be logged and placed in a Patient Valuables Envelope by the admitting Registered Nurse, LVN, or CNA, who shall secure the patient's or responsible party's signature on the Patient Valuables Envelope.

3. The house supervisor shall be responsible for transferring all properly logged patient monies or valuables to the hospital's safe according to established procedures.

B. Emergency Department Patients:

1. All patients who present to the Emergency Department shall have their property inventoried and documented on a Patient Property List form in the electronic medical record.

2. Patients may maintain control of their property but a Patient Property List form must be completed on all Emergency Department patients.

3. If the patient is admitted, the Emergency Department will bring the patient valuables to the Unit to which the patient shall be admitted so that the patient's property can be inventoried and secured according to established procedures.

C. Unit to Unit Transfers:

1. When a patient is transferred from one Unit to another, the receiving Unit must verify the Patient Property List form in the electronic medical record and re-inventory property, which was not otherwise locked in the hospital safe.

2. If after transfer to the new Unit, the patient requires property to be secured in the hospitals safe, the property will be secured according to established procedures.

D. SECURING PATIENT MONIES AND VALUABLES

1. Any money/valuables requested to be stored in the hospital safe shall be counted by two staff members and written in detail on the Patient Valuables Envelope.

2. The patient and responsible hospital staff shall each sign the Patient Valuables Envelope. During normal business hours, the hospital's house supervisor/RN shall be asked to countersign the Patient Valuables Envelope. Outside of normal business hours, the house supervisor shall be asked to countersign the Patient Valuables Envelope.

3. The patient shall receive a receipt of the Patient Valuables Envelope.

4. The house supervisor is responsible for transferring the Patient Valuables Envelope to the hospital's safe.

E. RELEASING PROPERTY

1. Upon discharge, or demand by the patient his or her property or valuables be returned, all property must first be inventoried.

2. All money and valuables of the patient, which have been stored in the hospital safe, shall be surrendered to the patient or the person responsible for the patient in exchange for a signed receipt.

3. Following the death of a patient, except in a coroner or medical examiner's case, all money and valuables of that patient, which have been stored, shall be surrendered to the person responsible for the patient, or the executor or the administrator of the estate in exchange for a signed receipt, within 30 days. Immediate written notice of the death of a patient without an agent or known heirs shall be given to the public administrator of the county as specified by Section 1145 of the Probate Code.

F. PROPERTY LOSS

1. If a loss of property occurs and it has not been turned in to the Nurse's Station or Security Department, the loss is a possible theft, and should be reported to Law Enforcement (refer to Policy #10-1033 Theft or Suspected Theft of Property). .

2. The hospital will not pay to reimburse any item without prior written authorization from Administration.

Reference:

California Healthcare Association Consent Manual 2002 – Ch. 21 Hospital Liability for Patient Valuables

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Descriptive Name: Securing Patient Monies/Valuables and Property Damage or Loss

Descriptive Type: Revised

Document Number: 10-1117

Attachments: Belonging Record

Author: Rochele Bailey, (Legal Counsel)
Andrea Carrasco/Ena Menezes

Typist: Andrea Carrasco

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Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	N/A	Date change only
Board of Directors		

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Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Use of Social Security Numbers

I. PURPOSE:

The broad use and public exposure of Social Security numbers (SSN) has been a major contributor to the tremendous growth in recent years in identity theft and other forms of credit fraud. The need to significantly reduce the risks to individuals of the inappropriate disclosure and misuse of SSN's, has in recent years led California and a few other states to take steps to limit their use and display.

II. POLICY:

A. Civil Code Sections 1798.85-1798.86 **prohibits** any entity to:

1. Post or publicly display Social Security Numbers,

2. Print Social Security Numbers on identification cards or badges,

3. Requiring people to transmit an SSN over the Internet unless the connection is secured or the number is encrypted,

4. Require people to log onto a web site using an SSN without a password, and

5. Print SSN's on anything mailed to a customer unless required by law or the document is a form or application.

III. PROCEDURE:

A. Tulare Regional Medical Center shall not mail to an individual patient or employee the following documents since these documents require social security numbers be on them for third parties to process them for payment:

1. A Unified Bill (UB92 form)

2. A Professional Bill (1500 form)

B. These forms will only be used for purposes of billing the patient's third party payer, who requires that such number be on the bill to process the claim for payment.

C. Tulare Regional Medical Center shall only mail a Demand Bill or a Patient/Guarantor Statement relating to medical services provided by the hospital to a patient. Both the Demand Bill and the Patient/Guarantor Statements do not include the patient's Social Security number.

D. Effective January 1, 2008, only the last four digits of the employees Social Security number may be displayed on the employees pay stub.

E. Any employee violating such policy may be subject to disciplinary action according to hospital policy #15-2015.

IV. References:

California Department of Consumer Affairs, Office of Privacy Protection, "Recommended Practices on Protecting the Confidentiality of Social Security Numbers" (Rev. April 2007)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Use of Social Security Numbers

Descriptive Type: Revised

Document Number: 10-1118

Attachments: None

Author: LuAnn Perry

Typist: Julie Gresham/Ena Menezes/Andrea Carrasco

Creation Date: 11/12/10

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Board of Directors	~~01/26/11~~	

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Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Notice of Privacy Practices (HIPAA)

I. Purpose

To outline the requirements of the hospital's privacy notice and its use as mandated by the Health Insurance Portability and Accountability Act.

II. Policy

The hospital will produce and maintain a notice of its privacy practices describing how the hospital staff uses and discloses protected health information.

III. Required Content of the Notice

A. The hospital notice of privacy practices will be designated by the hospital's Privacy Steering committee with the guidance of hospital counsel as to meeting compliance with all legal requirements as specified by HIPAA regulations and other law. The form must contain all of the core elements specified in the regulation and be written in plain language.

B. The contents of the notice must be communicated to all recipients and therefore the hospital may use alternative means of communicating with certain populations. Where a significant number or proportion of the population eligible to be served needs information in a language other than English in order to be effectively informed of the hospital privacy practices, the hospital shall take reasonable steps, to publish the notice in languages appropriate to such persons.

C. The staff should be attentive to the needs of individuals who cannot read.

IV. Uses and Disclosures of the Notice

A. The hospital's notice must describe all uses and disclosures of protected health information that the staff is permitted or required to make under this

rule without authorization, including those uses and disclosures subject to the consent requirements.

B. If applicable state law prohibits or materially limits the hospital's ability to make any uses or disclosures that would otherwise be permitted under the HIPAA regulations, the hospital must describe only the uses and disclosures permitted under the more stringent law.

C. The hospital's notice must separately describe each purpose for which the staff is permitted to use or disclose protected health information without authorization, and must do so in sufficient detail to place the patient on notice of those uses and disclosures.

D. With respect to uses and disclosures to carry out treatment, payment, and health care operations, the description must include at least one example of the types of uses and disclosures that the covered entity is permitted to make.

E. The hospital's notice will inform patients that they may be contacted for any of the following activities: providing appointment reminders, describing or recommending treatment alternatives, providing information about health-related benefits and services that may be of interest to the individual, or soliciting funds to benefit the covered entity.

F. The notice must state that all other uses and disclosures will be made only with the individual's authorization and that the individual has the right to revoke such authorization.

V. Individual Rights

A. The notice must describe patient' rights under the rule and how individuals may exercise those rights with respect to the hospital.

B. The notice must describe each of the following rights, as provided under the HIPAA regulations:

- the right to request restrictions on certain uses and disclosures, including a statement that the hospital is not required to agree to a requested restriction.
- the right to receive confidential communications of protected health information.
- the right to inspect and copy protected health information.
- the right to amend protected health information.

- the right to an accounting of disclosures of protected health information.

C. The notice should describe the right of an individual, including an individual that has agreed to receive the notice electronically, to obtain a paper copy of the notice upon request.

VI. The Hospital's Duties

A. The hospital must state in the notice that the staff is required by law to maintain the privacy of protected health information, to provide a notice of their legal duties and privacy practices, and to abide by the terms of the notice currently in effect.

B. The notice will contain a statement that hospital governing authority/management reserves the right to change its privacy practices and apply the revised practices to protected health information previously created or received.

C. It must also contain a statement describing how the staff will provide patients with a revised notice.

VII. Complaints

A. The notice must inform patients about how they can lodge complaints with the hospital if they believe their privacy rights have been violated.

B. The notice should read that all complaints will be directed to the hospital Privacy Officer.

C. The notice must state that the patient will not suffer retaliation for filing a complaint.

VIII. Contact

A. The notice must identify the hospital Privacy Officer as the point of contact where the patient can obtain additional information about any of the matters identified in the notice.

IX. Effective Date

A. The notice must include the date the notice went into effect. The effective date cannot be earlier than the date on which the notice was first printed or otherwise published. The hospital staff must highlight or otherwise emphasize any material modifications that it has made, in order to help the individual recognize such changes.

X. Revisions to the Notice

A. The hospital staff must adhere to the terms of the notice currently in effect. Should a material change be necessary to any of the uses or disclosures, the patient's rights, the hospital's legal duties, or other privacy practices described in the notice, management must promptly revise the notice and the affected policies and procedures accordingly.

B. Except when required by law, a material change to any term in the notice may not be implemented prior to the effective date of the notice in which such material change is reflected.

XI. Provision of the Notice

A. The hospital must provide the notice upon request of any person. The requestor does not have to be a patient.

B. The staff must provide the notice to patients to whom the hospital has a direct treatment relationship as of the first service delivery after the compliance date.

C. This requirement applies whether the first service is delivered electronically or in person. The hospital staff may satisfy this requirement by sending the notice to all of their patients at once, by giving the notice to each patient as he or she comes into the hospital or contacts the provider electronically, or by some combination of these approaches.

D. The hospital must prominently post the notice where it is reasonable to expect individuals seeking service to be able to read the notice. The notice must also be available on site for individuals to take on request. In the event of a revision to the notice, hospital must promptly post the revision and make it available on site.

E. The hospital must make the notice prominently available through its web site.

F. Should an individual receive the hospital's notice electronically, they retain the right to request a paper copy of the notice as described above. This right must be described in the notice of privacy practices.

XII. Documentation

A. The hospital must retain copies of each version of its notices of privacy practices issued for at least six years from the date of the creation of the documentation, or the date when the document was last in effect, which ever is later.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.

I. Our responsibilities to safeguard your protected health information.

We are required by law to provide you with this notice about the hospital's privacy practices that explains how, when, and why we use and disclose your protected health information. With some exceptions, we may not use or disclose any more than the minimum necessary protected health information to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the protected health information we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in all reception areas. You can also request a copy of this notice from the hospital's Privacy Officer or view a copy of the notice on our web site at www.tulareregional.org.

II. How your protected health information may be used.

A. We use health information about you for treatment purposes; obtain payment for treatment, and for healthcare operations.

For some of these uses or disclosures, we do not need your prior consent. Below, we describe the different categories of our uses and disclosures that do not need your consent and give you some examples of each category.

1. For treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of our healthcare team will then record the actions they took and their observations. That way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent healthcare provider with copies of various reports (lab, x-ray) that should assist him or her in treating you. If you were treated as an outpatient, we will provide your test results to the ordering physician via fax or courier.

2. To obtain payment for treatment. We may use and disclose your protected health information in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your protected health information to our billing department and your health plan to get paid for the health care

services we provided you. We may also provide your protected health information to our business associates, such as billing companies, claims processing companies, and others that process our health care claims. We may also release information to other providers that performed a service to you while here. For example: ambulance, radiologist and anesthesiologist, etc.

3. For health care operations. Health care operations" are certain administrative, financial, legal and quality improvement activities of a covered facility that are necessary to run its business and to support the core functions of treatment and payment. Here are a few activities that would fall under health care operations:

a. Conducting quality assessment and improvement activities
b. Conducting or arranging for medical review, legal and auditing services including fraud and abuse.
c. Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the facility.

By state or federal law, we may be required to report certain circumstances, wherein we may use and disclose your protected health information without your authorization. Below are a few of those examples:

4. When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, violent crime or domestic violence; also when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.

5. For public health activities. For example, we report information about births, deaths, and various contagious diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6. For health oversight activities. For instance, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

7. For purposes of organ donation. We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8. To avoid harm. In order to avoid a serious threat to the health and safety of a person or the public, we may provide patient protected health information to law enforcement personnel or persons able to prevent or lessen such harm.

9. For specific government functions. We may disclose patient protected health information of military personnel and veterans in certain situations. In addition, we may disclose patient protected health information for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

10. For workers' compensation purposes. We may provide patient protected health information in order to comply with workers' compensation laws.

11. Appointment reminders and health-related benefits or services. We may use patient protected health information to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer.

B. There are certain uses and disclosures to which you will have the opportunity object.

In the following situations, we may disclose your protected health information if we inform you about the disclosure in advance and you do not object. If there is an emergency and you cannot be given the opportunity to object, we may disclose your health information consistent with any prior expressed wishes if it is determined by a healthcare professional that it is in your best interests. If you are unable to consent in an emergency, you will be given the opportunity to object as soon as you are able to do so.

1. Patient directories. We may include your name, location in this facility, general condition, and religious affiliation, in our patient directory for use by clergy and visitors who ask for you by name, unless you object in whole or in part.

2. Disclosures to family, friends, or others. We may provide your protected health information to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All other uses and disclosures require your prior written authorization. In any other situation not described previously, we will ask for your written authorization before using or disclosing any of your protected health

information. If you choose to sign an authorization to disclose your protected health information, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't already taken any action relying on the authorization).

III. Your rights regarding your protected health information.

A. You have the right to ask that we limit how we use and disclose your protected health information. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. In most cases, you have the right to look at or get copies of your protected health information that we have, but you must make the request in writing. If we do not have your protected health information but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

D. If you request copies of your protected health information, we will charge you a fee of $15.00. Instead of providing the protected health information you requested, we may provide you with a summary or explanation of the information as long as you agree to that and to the cost in advance.

E. You have the right to get a list of instances in which we have disclosed your protected health information. The list will not include uses or disclosures made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14, 2003.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom your protected health information was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if

you make more than one request in the same 12-month period, we will charge you $5.00 for each additional request.

F. If you believe that there is a mistake in your protected health information or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. If the provider is unable to act on the amendment within 60 days, the provider may extend the time for action by no more than 30 days. The provider must give the individual a written statement and the reason for delay. We may deny your request in writing if the protected health information is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request your request and our denial be attached to all future disclosures of your protected health information. If we approve your request, we will make the change to your protected health information, tell you that we have done it, and others that need to know about the change to your protected health information.

G. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

H. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail) of any Breach (as defined by law) within 60 days of discovery. Such notice shall include a brief description of the Breach and the information involved, steps you should take to protect yourself from harm, and who to contact at Tulare Regional Medical Center for more information.

III. How to complain about our privacy practices.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may file a complaint with the person listed in Section V below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at the following address.

Office of Civil Rights
The U.S. Department of Health and Human Services
97 Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310
We will take no retaliatory action against you if you file a complaint about our privacy practices.

IV. Person to contact for information about this notice or to complain about our privacy practices.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Office of Civil Rights please contact: Internal HIPAA Privacy Officer at 869 Cherry Street, Tulare, CA 93274; (559) 685-3494 or by e-mail to hipaa@tulareregional.org

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Notice of Privacy Practices (HIPAA)

Descriptive Type: Revised

Document Number: 10-1120

Attachments: Notice of Privacy Practices

Author: LuAnn Perry

Typist: Julie Gresham

Creation Date: 03/02/10

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Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~05/26/10~~	

Effective Date: ~~05/27/10~~

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Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Hospital Departments

FROM: Administration

SUBJECT: Disclosure of PHI to Law Enforcement (HIPAA)

PURPOSE:

To ensure that Tulare Regional Medical Center adhere to the applicable laws as it pertain to Disclosure of Patient Health Information to Law Enforcement.

POLICY:

This policy identifies the circumstances under which protected health information (PHI) may be disclosed for a law enforcement purpose to a law enforcement official.

PROCEDURE:

I. **In Response to Legal Process or Law.**

The hospital staff may disclose PHI in compliance with and as limited by relevant requirements of: a court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer, or a grand jury subpoena.

The hospital staff may disclose PHI in compliance with and as limited by relevant requirements of: an administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized by law, provided that:

1. the information sought is relevant and material to a legitimate law enforcement inquiry;
2. the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
3. de-identified information could not reasonably be used to meet the purpose of the request.

All disclosure requests must be forwarded immediately to the Privacy Officer. The Privacy Officer will have the responsibility to provide the information to the hospital attorney to ensure the request is appropriate under the law prior to disclosure of PHI.

II. **Limited Information for Identification and Location Purposes.**

Hospital staff may disclose limited protected health information, specified below, in response to a law enforcement official's request for the information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person. The request should, if possible, be made in person with proof of identification; verbally if staff can confirm identification or in writing. The staff must document all requests granted disclosure in the patient's record. All documentation must be forwarded to the Privacy Officer for review.

The limited protected health information that may be disclosed in response to a law enforcement official's request for the above purpose is:

1. name;
2. address;
3. Social Security number;
4. date of birth;
5. place of birth;
6. type of injury,
7. a description of distinguishing physical characteristics, such as scars and tattoos, height, weight, gender, race, hair and eye color, and the presence or absence of facial hair such as a beard or moustache;
8. date and time of treatment,
9. ABO blood type and Rh factor, and
10. date and time of death, if applicable.

PHI associated with the following cannot be disclosed: DNA data and analyses; dental records; or typing, samples or analyses of tissues or bodily fluids other than blood (e.g., saliva).

The Privacy Officer must ensure that all hospital staff is properly trained to understand the definitions set forth in HIPAA and all that disclosures are proper and documented.

If a hospital staff member who is the victim of a crime discloses PHI to law enforcement officials about the suspected perpetrator of the crime, such information must be the limited information for identification and location purposes set forth above.

III. **Concerning Crime Victim**

A covered entity may disclose protected health information in response to a law enforcement official's request for such information about an individual who is or is suspected to be a victim of a crime, other than disclosures that are subject to paragraph (b) or (c) of this section, if:

(i) The individual agrees to the disclosure; or
(ii) The covered entity is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

(A) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;
(B) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and
(C) The disclosure is in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

The hospital staff may disclose PHI about a person who is or is suspected to be a victim of a crime, abuse or other harm to a law enforcement official, if:

1. The individual agrees to the disclosure; or
2. The hospital is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that the law enforcement official represents that:
   a. the information is needed to determine whether a violation of law by a person other than the victim has occurred and the information is not intended to be used against the victim; and
   b. immediate law enforcement activity that depends on obtaining the information would be adversely affected by waiting until the individual is able to agree; and
   c. the covered entity, in the exercise of professional judgment, determines that the disclosure is in the individual's best interests.

Disclosure of PHI may not be initiated by the hospital staff. A request for disclosure of PHI must be initiated by a law enforcement official.

The hospital staff must obtain the patient's agreement as a condition of disclosing the PHI about victims to law enforcement, unless the disclosure is permitted without authorization for public health activities, for victims of abuse, neglect, or domestic violence, or for law enforcement purposes as required by other law.

The required agreement may be obtained orally, and does not need a signed authorization.

If in the staff's professional judgment that to disclose information would not be in the patient's best interest and that harm could result from the disclosure, disclosure should not be made.

If the staff determines that the patient is a victim of a crime and may also be a fugitive or suspect and law enforcement officials are requesting PHI because the individual is a suspect (and thus the information may be used against the individual), refer to Part II. above concerning limited information for identification and location purposes.

IV. **In Regards to Decedents.**

The staff may disclose PHI about an individual who has died to a law enforcement official for the purpose of alerting law enforcement of the death if the staff has a suspicion that such death may have resulted from criminal conduct.

The staff should refer all incidences of suspicious death to the hospital's Privacy Officer for determination of if and how the disclosure should be made.

The hospital staff is permitted to disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.

PHI that can be disclosed to coroners and medical examiners includes identifying information about other persons that may be included in the individual's medical record.

The hospital staff is permitted to disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary for funeral directors to carry out their duties, the hospital may disclose the protected health information prior to, and in reasonable anticipation of, the individual's death.

V. **In Response to Criminal Conduct on the Hospital Premises.**

The hospital staff is allowed to disclose PHI to law enforcement officials that the staff believed in good faith constitutes evidence of a crime committed on the premises.

VI. **In Response to Reporting Crime in Emergencies.**

The hospital's emergency room staff can disclose protected healthcare information to law enforcement officials when providing emergency health care in response to a medical emergency, other than such emergency on the premises of the hospital if such disclosure appears necessary to alert law enforcement to:

1. the commission and nature of a crime,
2. the location of such crime or of the victim(s) of such crime, and
3. the identity, description, and location of the perpetrator of such crime.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Disclosure of PHI to Law Enforcement (HIPAA)

Descriptive Type: Revised

Document Number: 10-1121

Attachments: None

Author: LuAnn Perry

Typist: Julie Gresham/Gillian Busch
Ena Menezes/Andrea Carrasco
Revision Date: 02/13/18

Creation Date: 10/29/10

Prev. Dist. Date: 04/23/06

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~06/22/11~~	

Effective Date: ~~06/23/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

HIPAA Compliance: 164.512 (f) (1)
164.512 (f) (2)
164.512 (f) (4)
164.512 (f) (5)
164.512 (f) (6)
164.502 (j) (2)

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: All Hospital Departments

FROM: Administration

DELETE

SUBJECT: Access to Minimum Necessary Protected Health Information (HIPAA)

Policy

HIPAA Privacy Rule 164.502(b) indicates that Tulare Local Health Care District (and its employees) must minimize the use and disclosure of protected patient health information. Only when it is *necessary* to accomplish an appropriate purpose should protected health information be used, disclosed, or requested. Federal law refers to this as the "minimum necessary" standard.

Hospital staff members may access only the minimum protected patient health information necessary to carry out their job responsibilities. Management will review the access of each department's job classifications and determine, in their professional judgment, the minimum protected health information each classification will need to perform their job properly. Each determination must be documented and reviewed by the Privacy Officer for compliance with the regulations.

The staff must limit requests to other covered entities for individually identifiable health information to that which is reasonably necessary to accomplish an appropriate purpose. This procedure must be documented and verified to be in compliance with the regulation.

In certain circumstances, the hospital staff may rely on the judgment of the party requesting the disclosure as to the minimum amount of information that is needed for the stated purpose. Such reliance must be reasonable under the particular circumstances of the request. This reliance is permitted when the request is made by:

- A public official or agency for a disclosure permitted by the HIPAA regulations.
- Another covered entity.
- A professional who is a workforce member or business associate of the covered entity holding the information.

Disclosures for treatment purposes (including requests for disclosures) between the hospital and another health care provider are explicitly exempted from the minimum necessary requirements.

For non-routine disclosures, see policy #13-9032 Accounting of Disclosure of Protected Health Information (HIPAA).

As a covered entity, Tulare Local Health Care District may not use, disclose or request "an entire medical record," in cases where the "minimum necessary" limitation applies, except where the entire record is "specifically justified" as the amount of information reasonably necessary to accomplish the purpose of the use, disclosure or request.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Access to Minimum Necessary Protected Health Information (PHI) (HIPAA)
Descriptive Type:	Revised
Document Number:	10-1122
Attachments:	None
Author:	Rick Elkins
Typist:	Julie Gresham
Creation Date:	7/06/06
Prev. Dist. Date:	04/28/06
Revision Notes:	Legal Counsel 1/19/07 General Board 01/31/07
Effective Date:	02/01/07
Forward To:	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	
HIPAA Compliance:	164.502 (b) 164.514 (d)

Policy # 10-1122

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments and Tulare Advance Register

FROM: Administration

SUBJECT: Release of Patient Information (HIPAA)

I. Patient Information Defined

Patient information is defined as Name, Location, Condition (described in general terms that do not communicate specific medical information about the individual) and Religious Affiliation of any patient of Tulare Local Health Care District. Protected Health Information refers to the Medical Record and is addressed in a separate policy. (Policy # 13-9006 Patient Right to Access Protected Health Information)

I. Patient Options Regarding Release Of Patient Information

The hospital's first and foremost duty is to its patients. This duty includes protecting a patient's privacy and guaranteeing the confidentiality of their medical care. Patients of Tulare Local Health Care District have a choice of whether or not the hospital may release certain information about them upon request by another party.

Upon admission the patient is asked if patient information may be released. If the patient chooses to withhold release of such information, the patient shall fill out the **REQUEST TO WITHHOLD PUBLIC RELEASE OF INFORMATION** form (yellow paper, see attached) and distribute copies to PBX, Security and the Nursing Supervisor's Office. The patient's preference is entered in the Registry Menu of HMS by the Admissions Clerk. The original (yellow sheet) will be placed in the patient's chart.

If the patient later decides to change their status regarding 'Release of Information', they must fill out and sign the **CHANGING STATUS REGARDING 'RELEASE OF INFORMATION'** form (see attached). The Unit Secretary will enter changes in the Patient Maintenance screen of HMS. A copy of the **CHANGING STATUS REGARDING 'RELEASE OF INFORMATION'** form will be forwarded to PBX, Security and the Nursing Supervisor's Office. The original **CHANGING STATUS REGARDING 'RELEASE OF INFORMATION'** form will be placed in the patient's chart.

In regards to the patient who upon admission is incapacitated or is seriously injured to the point that inquiring about 'Release of Information' status would delay treatment, the decision regarding 'Release of Information' status will be made at

the hospital's discretion, in the best interest of the patient if there is not someone available to make the decision on behalf of the patient. (See Special Situations Section E.) If the hospital chooses not to release patient information, the nurse will fill out a Request to Withhold Public Release of Information form (yellow paper) on behalf of the patient. The clerk will distribute copies to PBX, Security and the Nursing Supervisor's Office immediately. The original will be placed in the patient's chart along with a laminated sheet flagging the need for hospital staff to discuss 'Release of Information' status with the patient when they regain consciousness or are capable of making an informed decision. The patient may choose to change the status and must then fill out a Changing Status Regarding 'Release of Information' form. The Unit Secretary will enter changes in the Patient Maintenance screen of HMS. A copy of the revised face sheet will be forwarded to PBX, Security and the Nursing Supervisor's Office. The original **Changing Status Regarding 'Release of Information'** form will be placed in the patient's chart. (See attached flow sheet.)

II. Patient Directory

The Patient Directory is available to limited hospital staff and auxiliary for use in referencing/directing inquiries from the general public concerning individuals currently admitted as inpatients to the hospital.

The Patient Directory will contain the patient's name, religious affiliation, release of general condition (Yes or No) and location in the hospital. This information will be available for each patient unless the patient specifies that they do not want the information included in the Patient Directory.

The hospital reserves the right to deny Release of Patient Information if it feels that release may cause a security risk to the patient, hospital staff or other patients.

III. Requests For Patient Information

Disclosure of information concerning the patient's location in the hospital to persons who inquire about the patient by name is permitted. However, release of such information is intended to facilitate visits by family and friends, as well as the delivery of gifts and flowers. Caution should be exercised in disclosing this information over the telephone, even where such disclosure is believed to be proper, except as necessary to direct the inquiring party in general terms to the appropriate location within the hospital. Precise information (e.g. floor or room number) are best disclosed only on a face-to-face basis so that there is an opportunity to verify the individual's purpose or intended use of this information.

The Auxiliary members, working at the lobby information desk, shall have access to the Patient Directory and may give out the patient's location when asked for **by name** if the patient is listed in the directory.

Requests for detailed information beyond acknowledgement of the patient's presence in the hospital and the general statement of the patient's condition are to be referred to the patient's attending physician and the patient's personal representative. When this is not practical, the CEO or designated representative shall be contacted. The CEO or designee shall contact the patient and attending physician to secure consents to release details of the patient's hospitalization to the extent indicated by the patient.

The patient's right of privacy and the physician's similar right of privacy shall be respected as provided for in this policy and under existing California State Laws and applicable Federal Laws.

IV. Personal Representatives

The hospital staff may disclose to a person involved in the current health care of the patient (such as a family member, other relative, close personal friend, or any other person identified by the individual) the protected health information (more than general patient information listed in the Patient Directory) directly related to the person's involvement in the current health care of the patient.

The hospital staff may disclose protected health information to notify or assist in notification of family members, personal representatives, or other persons responsible for a patient's care with respect to an individual's location, condition, or death.

When the patient has the capacity to make his or her own decisions, the hospital may disclose the protected health information to another person involved in the patient's healthcare only if the staff:

- obtains the patient's agreement to disclose to the third parties involved in their care **and**

- provides the individual with an opportunity to object to such disclosure and the individual does not express an objection **or**

- reasonably infers from the circumstances, based on the exercise of professional judgment, that the individual does not object to the disclosure.

When the opportunity to agree or object to the use or disclosure cannot practicably be provided due to the patient's incapacity or an emergency circumstance, the hospital staff may, in the exercise of the professional judgment of a licensed

healthcare professional, determine whether the disclosure is in the individual's best interests and if so, disclose only the protected health information that is directly relevant to the person's involvement with the patient's health care.

Should the staff suspect that an incapacitated patient is a victim of domestic violence and that a person seeking information about the patient may have abused the patient, the staff should not disclose information to the suspected abuser if there is reason to believe that such a disclosure could cause the patient serious harm.

When disclosure is made, care must be taken to provide only information directly related to the patient's current condition. All incidents of a disclosure and the circumstances governing it must be documented in the patient's medical record including objections to disclosure and reason for inferring that consent was implied.

The staff may disclose functional information to individuals assisting in a patient's care such as information about a person's mobility limitations to a friend driving the patient home from the hospital.

The staff may also use professional judgment and experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to act on a patient's behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of protected health information.

V. Inquiries From The News Media:

All inquiries from the media shall be directed to the Community Relations Department. A patient's right to privacy surpasses the media's desire for information – even if some of the information can be considered a matter of public record. Information about the general condition of an inpatient, outpatient or emergency department patient may be released **only if the inquiry specifically contains the patient's name.** Disclosure of a patient's **room** location to the media is prohibited without the patient's written authorization.

The media may be denied access to a patient if it is determined that the presence of photographers or reporters would aggravate the patient's condition or interfere with hospital care.

To safeguard patient privacy, a Community Relations Department employee or designee will accompany media representatives at all times when they are in the hospital facility.

Under HIPAA, the following activities require prior written authorization from a patient:

- Issuing a detailed statement (e.g. anything beyond the one-word condition) regarding the nature of the patient's illness or injury, his or her treatment and prognosis
- Photographing or videotaping patients
- Interviewing patients

If the patient is a minor, permission for any of these activities must generally be obtained from a parent or legal guardian, unless the information concerns health care services that the minor can obtain without the consent of a parent or guardian. (See Special Situations.)

As long as the patient has not requested that information be withheld, you may release the patient's **one-word condition** and location without obtaining prior patient authorization. It is the hospital's duty not to report any information that may embarrass a patient. Such information could include the room location of the patient (e.g. admission to an obstetrics unit following a miscarriage or admission to an isolation room for treatment of an infectious disease, etc.)

Additionally, a patient's location within the hospital should not be reported or confirmed if that information could potentially endanger the patient (e.g. the hospital has knowledge of a stalker or abusive partner, etc.)

A. Patient's General Condition

1. UNDETERMINED – Patient is awaiting physician assessment.
2. GOOD – Vital signs are stable and within normal limits. Patient is conscious and comfortable. Indicators are excellent.
3. FAIR – Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.
4. SERIOUS – Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
5. CRITICAL – Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.
6. TRANSFERRED – To another facility.

B. The Death of a Patient

The death of a patient is considered to be a "patient condition" and may be disclosed using this one-word description. However, exercise additional care with respect to disclosure of a patient's death, ensuring that all reasonable efforts have been made to notify the patient's next-of-kin prior to the patient's death being made public.

A patient's death is not routinely announced by the hospital, but rather by the patient's physician or the coroner.

Verify that there has been no objection to disclosure from the patient's family or other legal representative and that next-of-kin have been notified (or a reasonable attempt has been made) prior to the hospital making any announcement of a patient's death.

Additional information about a patient's death including the date, time and cause of death, should not be released without written authorization from a legal representative of the deceased. Again, this information typically comes from a patient's physician, not the hospital.

Refer to policy #13-11,003 Community Relations Responsibilities and Guidelines.

C. Matters of Public Record

Matters of public record refer to situations that are reportable by law to public authorities such as law enforcement agencies, the coroner or public health officer. Information that is included on police logs also is considered to be matters of public record (i.e., the transport of car accident victims to a hospital, etc.).

However, public record cases are no different than other cases with regard to the release of information. Thus, even though public record cases may result in increased media inquiries, patient privacy must be protected as in other situations including the HIPAA requirement that information be released only if the inquiry specifically contains the patient's name.

There are numerous state statutes that address reporting incidents ranging from child abuse to gunshot wounds. The fact that certain confidential information is reported to a government agency does not make that information public and available to the news media.

All media questions on matters of public record will be referred to the appropriate agencies (e.g. police, fire, coroner's office, etc.) The public entity will decide based on the laws applicable to it, whether it can release any or all of the information it has received.

VI. Special Situations

A. Public Figures and Celebrities

The standards for release of information are no different for public figures or celebrities than for other patients. However, given the likelihood of media

interest, verification should be made with the patient (or the patient's representative) whether there is objection to the disclosure of information to the media. Refer to policy #13-11,003 Community Relations Responsibilities and Guidelines.

B. Community Disasters

In disaster situations, the need to keep the public informed must be balanced with the privacy rights of patients and their families. Information may be released that is beneficial to the public good, but extra care must be taken to protect information that can be linked to a specific patient.

Rules governing the release of patient information to the media do not change in disaster situations – **a reporter must have a patient's name before any information can be released to the media.**

1. It is desirable to notify next-of-kin before releasing patient information, however, in disaster situations involving multiple casualties it may be necessary to share patient information with other hospitals and/or rescue/relief organizations prior to next-of-kin being contacted.

2. The number of patients that have been brought to the facility may be released by gender or age gourp (e.g. adults, teens, children, etc.) and the general cause of their treatment needs (an explosion, earthquake, etc.) as long as it is not identifiable to a specific patient.

3. Patient information may be released to other hospitals, health care facilities and relief agencies in situations where multiple facilities are receiving patients from one disaster.

   Specifically, hospitals may disclose patient information (e.g. location, general condition or death) to a public or private organization assisting in relief efforts for the purposes of notifying family members or others responsible for a patient's care.

D. Identity of Physician

The attending physician's name shall not be given to the news media without the physician's prior approval.

E. When a Patient is incapacitated

When a Patient is incapacitated, but has previously designated a representative to make health care decisions (e.g. closest available relative, conservators, designated agent or surrogates under a Power of Attorney for Health Care or Advance Directive), the designated individual also has the right to authorize (or object to) the release of the patient's information.

If a patient is incapacitated and there is no designated representative, the hospital may disclose some or all of the allowed information if such disclosure is consistent with a prior expressed preference of the patient. However, the patient must be informed of the use or disclosure of information as soon as it is practical to do so.

F. Unidentified Patients

Patients, who cannot be identified through any means (e.g. personal identification, police or dental records, etc.), may have a photo released to the news media in order to help locate the patient's next-of-kin. Under HIPAA, however, certain legal determinations must first be made.

- Before a hospital may provide the news media with any information about a "John Doe" patient, the hospital must first determine whether or not the patient is legally "present or otherwise available" and whether the patient has the capacity to make health care decisions.

- If a "John Doe" patient is determined to be both "present and otherwise available" and is not incapacitated, information may be released only if the patient agrees or is provided a reasonable opportunity to object and does not do so.

- However, if the unidentified patient is incapacitated and is not "present and otherwise available," the hospital may disclose only the minimum necessary information that is directly relevant to locating a patient's next-of-kin, if doing so is in the best interest of the patient. Under no circumstance, however, may a patient's mental health, developmental disability, HIV or substance abuse information be released.

G. Minors

HIPAA defers to state law with respect to the rights of parents to obtain access to or control the disclosure of information concerning their children. Under California law, when a parent or guardian has the authority to make medical decisions on behalf of a child, that parent or guardian also has the right to object to (or authorize) disclosure of medical information to the media.

In those cases where the minor has the legal authority to consent to a health care service, that minor also has the ability to object to (or authorize) the release of information regarding that health care service, regardless of whether a parent or guardian has given authorization.

It is possible that minors may receive some health care services for which they can legally consent and other treatments requiring the authorization of a parent or guardian. In these cases, the minor has the authority to object to (or

authorize) the disclosure of some medical information, while the parent or guardian has this authority for the other services.

H. Emancipated Minors
Minors who have been legally emancipated generally have the authority to make health care decisions for themselves. In these circumstances, emancipated minors also have the ability to authorize (or object to) the disclosure of their health information.

However, in those circumstances when a parent or guardian has the right to make health care decisions for an emancipated minor, the parent or guardian has the right to object to (or authorize) the disclosure of the health information involved.

References:

Federal Register, Part II, Department of Health and Human Services, Office of the Secretary, 45CFR Parts 160 and 164 Standards for Privacy of Individually Identifiable Health Information; Final Rule

HMS Monitor, Healthcare Management Systems, Inc., HIPAA Policies and Forms

Guide to Release of Patient Information to the Media – California Healthcare Association

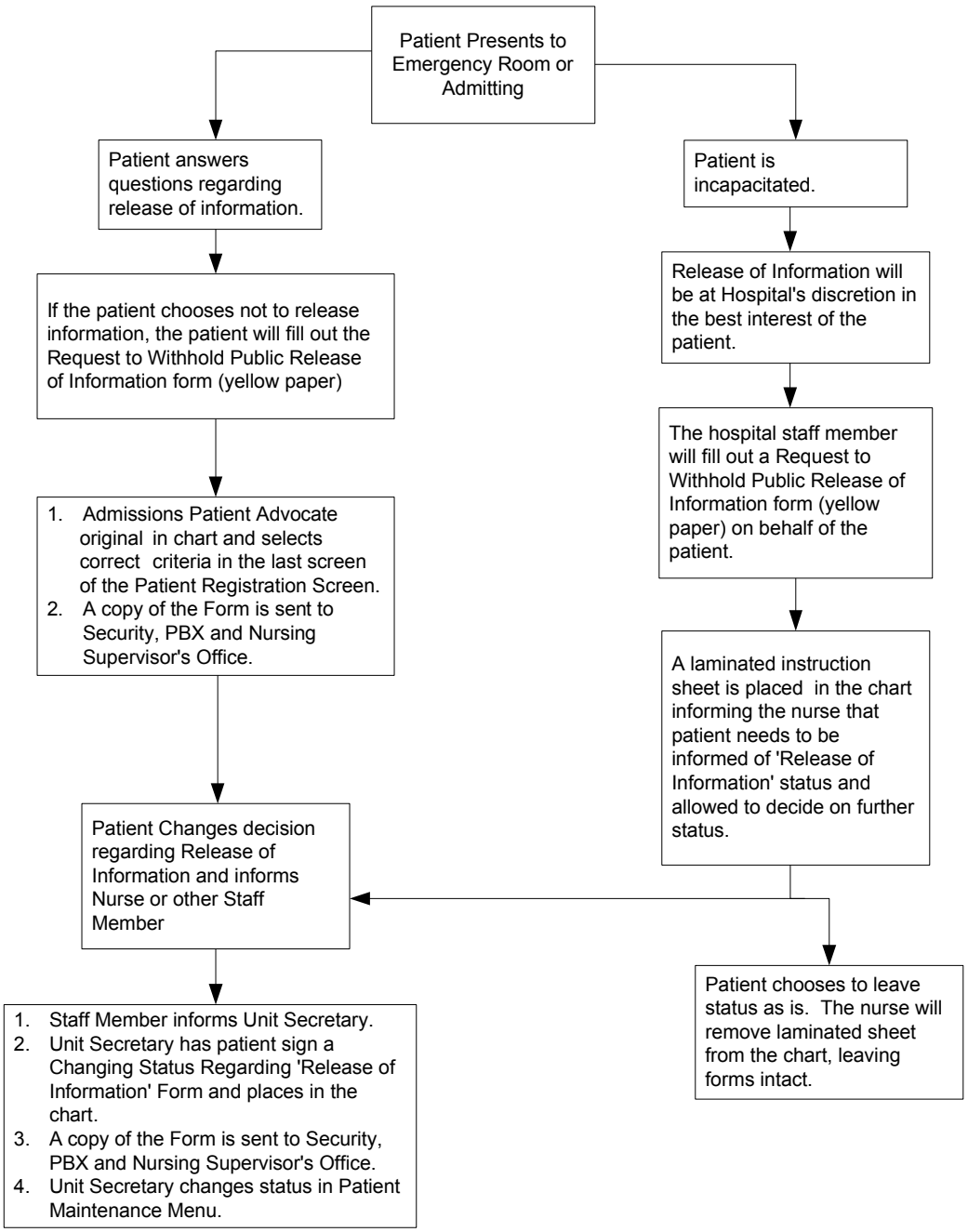
CHA Consent Manual, 2002, 29th Edition

CHA Minors and Healthcare Law, 2002, 4th Edition

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Release of Information Flowchart



TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

REQUEST TO WITHHOLD PUBLIC RELEASE OF INFORMATION

Patient's Name: _____

☐ I do not want any information about me, including my general medical condition and my location within the hospital, to be made available to the public. I understand the hospital cannot effectively screen the identity of persons making inquiries, so this prohibition extends to *all* callers, which may include family, friends and clergy.

☐ I do not want my name or religious affiliation given to a member of the clergy, such as a priest or rabbi, if they do not ask for me by name.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/parent/conservator/guardian)

If signed by other than patient, indicate relationship: _____

Witness: _____

Hard copies to be distributed to:

pc: Chart (Original)
PBX
Security
Nursing Supervisors

SOLICITUD PARA PROHIBIR LA DIVULGACIÓN DE INFORMACIÓN AL PÚBLICO

Nombre del Patiente: _____

☐ No deseo que ninguna información acerca de mí, include mi condición médica general y mi ubicación dentro del hospital esté a disposción del público. Entiendo que el hospital no puede efectuar una identificación sistemática eficaz de las personas que hacen indagaciones, por lo tanto esta probibición se extiende a todas las personas que llamen, lo cual puede incluir a mis familiars, amigos y clero.

☐ No deseo mi nombre o afiliación religiosa dada a un miembro del clero, tal como un sacerdote o un rabbi, si él no pide mí por nombre.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(patiente/padre/madre/conservador/tutor)

En caso de firmarse por una persona que no sea el paciente, indique la relación:

_____

Testigo (Witness): _____

Hard copies to be distributed to:

pc: Chart (Original)
PBX
Security
Nursing Supervisors

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

CHANGING STATUS REGARDING 'RELEASE OF INFORMATION' FORM

PATIENT NAME: _____ **DATE:** _____ **TIME**

MEDICAL RECORD NUMBER: _____ **ROOM NUMBER:** _____

MARK APPROPRIATE BOX

☐ Do not release information. ☐ Yes – Release Information

☐ Possible security risk to patient, hospital staff or other patients.

INITIATED BY:

_____
STAFF NAME

_____
TITLE

_____
SIGNATURE

REASON FOR CHANGE: _____

_____

_____

_____
AUTHORIZED SIGNATURE

Hard copies to be distributed to:

pc: Chart (Original)
PBX
Security
Nursing Supervisors

Descriptive Name:	Release of Patient Information
Descriptive Type:	Revised
Document Number:	10-1123
Attachments:	Booklet - Guide to Release of Patient Information to the Media - CHA (With Original)
Author:	Rick Elkin
Typist:	Julie Gresham/Andrea Carrasco/Ena Menezes
Creation Date:	7/06/06
Prev. Dist. Date:	9/25/03
Revision Notes:	General Board 01/03/07
Revision Date:	02/13/18
Effective Date:	~~01/04/07~~
Forward To:	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and distribution – Administration
Comments:	
HIPAA Compliance:	164.510

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: All Departments
FROM: Administration

DELETE

SUBJECT: Consent versus Authorization (HIPAA)

The terms “consent” and “authorization” have specific legal meanings. The requirement to obtain “consent” applies in different circumstances than the requirement to obtain an “authorization.” In content, “consent” and an “authorization” differ substantially from one another.

A “consent’ allows use and disclosure of protected health information only for treatment, payment, and health care operations. It may be written in general terms and should refer the individual to TLHD’s Privacy Practices Notice for further information regarding uses and disclosures of protected health information. It allows use and disclosure of protected health information by TLHD, but not by other persons (third parties). For consent requirements, see 45 CFR section 164.506.

Authorization, unlike consent, grants authority to use and disclose protected health information for purposes other than treatment, payment, and health care operations. TLHD must obtain an “authorization” for all uses and disclosures not covered by “consent.” An “authorization” must be written in specific terms. It may allow use and disclosure of protected health information by TLHD or by a third party. TLHD may not refuse to treat an individual based on the fact that they refuse to sign an authorization. For further information regarding “authorizations” see 45 CFR section 164.508.

Resolving Conflicts between Consent and Authorization

If the hospital staff has obtained a patient’s consent to use or disclose protected health information and is asked to disclose protected health information pursuant to another form of written legal permission from the patient, such as an authorization obtained by another person or entity, the staff must adhere to the more restrictive document.

Should the hospital’s consent conflict (i.e. contain inconsistencies) with the terms of another written legal permission from the patient, the hospital staff must consider any limitations on its uses or disclosures resulting from the notice provided to the patient or from restrictions to which it has agreed.

If a patient’s consent is found to be in conflict with another written legal permission, the issue is to be referred to the hospital Privacy Officer. The Privacy Officer will make the

Board of Directors: 01/3107

determination as to how the patient's health information will be disclosed or consult with hospital legal counsel for guidance.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Consent versus Authorization (HIPAA)
Descriptive Type:	New Policy
Document Number:	10-1124
Attachments:	None
Author:	Rick Elkins
Typist:	Julie Gresham
Creation Date:	7/06/06
Prev. Dist. Date:	9/25/03
Revision Notes:	Legal Counsel -1/19/07 General Board 01/31/07
Effective Date:	0201/07
Forward To:	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and distribution – Administration
Comments:	HIPAA Compliance: 45 CFR section 164.506 45 CFR section 164.508

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

DELETE

SUBJECT: Cell Phone within TLHD Facility

This policy is established to set criteria for the use of cell phones within Tulare Local HealthCare District facilities.

Cell phones may be used within the hospital including patient care areas by visitors, patients, physicians and staff. However, if at any point a staff member is concerned or witnesses interference to patient care monitoring devices, appropriate action will be taken and the cell phone being used may be asked to be turned off. Biomedical may also be called for an evaluation.

Employees may use cell phones only when away from their work area and are on a meal or rest breaks. Employees violating said policy will be disciplined according to Hospital Policy #15-2015 Disciplinary Action.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: 11/20/14 (10) Administration General:
Cell Phone Use within TLHD Facility

APPROVED: 10-1125

Board Of Directors: 11/19/14

Descriptive Name: Cell Phone Use within TLHD Facility

Descriptive Type: Revised Policy

Document Number: 10-1125

Attachments: None

Author: Lionel Machado

Typist: Melissa Arend

Creation Date: 1/19/04

Revision Date: 08/21/14

Prev. Dist. Date: 02/06/04

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	08/21/14	
Board of Directors	11/19/14	

Effective Date: 11/20/14

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Patient Identification (of Known and Unknown Individuals)

I. PURPOSE

To prevent a possible error in patient identification when administering medications, administering blood products, collecting blood samples and other specimens for clinical testing, performing tests or procedures, calling critical test results, accepting verbal or telephone orders, writing orders, and when the patient requires a special diet, and/or a meal or snack is delivered that is part of a special diet.

II. POLICY

It is the policy of Tulare Regional Medical Center to ensure that all patients are properly identified using **two patient identifiers** (neither to be the patient's room #) prior to any specimen collection, medication administration, transfusion, or treatment.

Patients are to be actively involved in the identification process. Patients who are considered reliable to do so should confirm their own identity by orally providing their name, and date of birth. For patients who are unresponsive or who may not be considered reliable (i.e. confused) it is permissible to have a family member identify the patient.

The patient identification band shall be compared with their medical record.

Note: The involvement of a single caregiver is acceptable as long as the other components of patient identification are satisfied.

Effective Date: 05/29/14 (10) Administration
General:
Patient Identification (of Known And Unknown Individuals)
10-1126

APPROVED:

Medical Executive Comm.: 05/14/14

Board Of Directors: 05/28/14

Containers used for blood and other specimens are labeled with 2 patient identifiers for the patient in the presence of the patient.

III. PRINCIPLES OF IDENTIFICATION

A system for positive identification of all hospital patients fulfills four (4) basic functions:

A. Provides positive identification of patients from the time of admittance or acceptance for treatment.

1. This identification system shall apply to patients in all areas of the hospital.

B. Provides a positive method of linking patients to their medical records and treatment.

C. Minimizes the possibility that identifying data can be lost or transferred from one patient to another.

D. Improves the accuracy of patient identification.

IV. PATIENT IDENTIFICATION POLICY

Hospital Identification Arm Band:

A. There are four types of bands provided by the hospital depending on the current status of the patient:

1. The standard hospital identification band. (White-pre-printed)
2. The Emergency Department band. (White with Yellow Stripe)
3. The crossmatch band. (Yellow)(Yellow)
4. Temporary armband (White, hand written)
5. The TRMC color coded claps as assigned appropriately.
6. TRMC Patient Identification/Band Usage by Departments Table (See attachment A).

B. The bands are used as follows:

1.The standard hospital identification band is a tamperproof, nontransferable identification band prepared and affixed to the patient by the admitting staff with exception of patients here for brief outpatient testing (i.e. outpatient lab, x-ray, etc., see VII. below).

The identification band will include the patient's full name, patient number, and medical record number, date of birth, age, sex and attending physician.

2. The Emergency Department band is used if the patient is an emergency department admission. An emergency department identification band is prepared as soon as possible upon patient entry to the emergency department treatment area. The identification band will be affixed to the patient and will list the patient's full name, emergency department patient number, medical record number, sex and date of birth.

If the Emergency Department patient is converted to inpatient status, the patient will have a hospital identification band applied upon admission to an inpatient care unit.

Note: The Emergency Department band (White with Yellow Stripe) shall remain on the patient and will only be removed if the patient is discharged from the Emergency Department or admitted to the hospital only after a standard hospital identification band is placed on the patient.

C. Before any non-emergency procedure is conducted, the identification band shall be on the patient and will be checked by the responsible care provider for the following **<u>two identifiers</u>** to ensure that the right patient is involved:

1. **Patient name**
2. **Patient date of birth (if newborn, verify medical record number)**

D. It is suggested that staff also verbally assess the patient to assure proper identification, asking the patient's name and matching the verbal confirmation to the written information on the patient identification band.

1.If the patient's date of birth is **not** available, the second identifier will become the **patient number or medical record number**.

E. Patient identification must be confirmed using the **<u>two-identifier</u>** system prior to conducting healthcare procedures. Procedures may include, but are not limited to: administration of medication, transfusion of blood or blood

components, obtaining blood or other specimens from the patient, performing a treatment, performing a diagnostic test (i.e., diagnostic radiographic study), distributing a diet tray and sending patients to another department.

1. No non-emergency procedure shall be conducted when the patient's identity cannot be verified because the imprinted band is illegible or missing.

2. Defective or missing bands shall be replaced immediately with new bands.

3. Laboratory specimens will not be collected unless a temporary or permanent identification armband is present.

F. Each healthcare provider conducting assessments on the patient shall include a check of the patient's identification band to assure the band is present and legible, as a routine component of the patient assessment process.

G. The daily nursing staff rounds shall include spot checking the patients to ensure that they are wearing identification bands and that the information is legible.

H. In the event of death, the patient identification band shall remain on the patient's body.

V. FOR PATIENT'S WITH AN UNKNOWN IDENTITY

A. John/Jane Doe patient name and a patient number will be used as **two identifiers** to temporarily identify patients only when information is not available due to:

1. Unconscious individual – correctly identify individual as soon as available.

2. Incompetent/demented individual – correctly identify individual as available through individual's representative or as soon as individual becomes competent.

3. Deceased individual – correctly identify individual as soon as possible.

4. In the case of multiple John Doe/Jane Doe patients for example, trauma victims, mass casualties, consider a middle initial or digit to differentiate between such patients.

5. Patient information will be updated as soon as actual patient identification can be made. The computer system will be updated with the appropriate patient information using the same patient number and medical record number. A new patient face sheet and Identification band will be made and affixed to the patient.

B. Procedure

1. Emergency Department personnel will call the Emergency Department Registrar immediately following radio contact with EMS when a "critical" patient is enroute to TDH. Upon notification, the ED (Registrar) will assign a temporary identification armband (White with Yellow Stripe) with the pseudonym John/Jane Doe along with a three (3) letter prefix and a four (4) digit ID number (E.g. Doe, John LDH9279). This armband (green) will be attached to the patient by the (Registrar) immediately upon the arrival to the ED. If the Registrar is unable to attach the armband to the patient, the Registrar will give the armband to the nurse to assist in immediately placing the band on the patient.

2. After the Registrar has attached the temporary tamper proof armband (White with Yellow Stripe) to the patient, the (Registrar) will affix one of the armband labels to the patient's face sheet. This will become part of the patient's permanent medical record.

3. Once the patient is registered in Med Series 4, a second identification armband will be generated with John or Jane Doe with the same three (3) letter prefix and four (4) digit numbers and will be attached to the patient by the Patient Advocate.

4. When positive identification is established on an unidentified patient, information will also be updated in Med Series 4. All paperwork will be updated and given to the Emergency Department personnel to attach to the patient's chart for medical records and the updated armband will be attached to the patient by the Patient Advocate.

   Note: the temporary armband (White with Yellow Stripe) shall remain on the patient and will only be removed if the patient is discharged from the ED or admitted to the hospital only after a permanent ID band is placed on the patient.

VI. OTHER TYPES OF BANDS USED IN THE HOSPITAL

A. Do Not Resuscitate (DNR) patient identification system:

1. Upon notification of a patient's DNR status (verified by the patient's physician), a second arm band which is blue in color indicating the DNR status, shall be affixed to the patient's wrist.

2. Blue armbands are only to be utilized to identify those patients who have requested or have been made a DNR status. Blue arm bands are never to be utilized for any other purpose.

3.A DNR sticker is placed on the rand card and on the front of the patient's chart.

4. If the DNR order is rescinded, the blue DNR identification band will be immediately removed from the patient and the DNR sticker will be removed from the Rand card and patient's chart.

C. ALLERGY BAND – Patients with medication, food, latex or any other identified allergies shall be written on a "red" allergy band and be affixed to the patient.

D. INFANT IDENTABAND – Will be applied immediately following birth, identically numbered identabands stating the infant's sex, date and time of birth, medical record number, and mother's name and mother's physician's name shall be affixed to infant's wrist and ankle and to the mother's wrist.

E. CROSSMATCH BAND (Yellow) – Will be affixed to patients who may require transfusion services. The label from the "yellow" armband **must be** affixed to the blood specimens submitted to Blood Bank at the patient's bedside at the time of phlebotomy (reference: AABB Technical Manual, 17th Edition, 2011).

F. LIMITED ACCESS BAND-Patient's identified as dialysis, mastectomy patients or patients with limited accessibility shall have a "green" band placed on the non-dominant arm to alert staff of no needle sticks. Staff is to write on band with permanent black marker "No Needle Sticks Ever".

G. BROSELOW COLOR CODED WRISTBANDS - once weight is obtained on pediatric patients, the child will be banded with the color of band which correlates to the Broselow tape. This band shall remain on the patient until discharge.

VII. IDENTIFICATION OF PATIENTS IN OUTPATIENT AREAS

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

A.Patients receiving outpatient testing, i.e., Lab draws, X-ray's, respiratory testing, etc., shall be identified by comparing the individual's stated name and date of birth, with the name and date of birth on the requisition and/or physician's orders.

B. Respiratory Outpatient: EEG patients will present Patient Identification Card, Driver's License, and Sleep Lab patients will be Identified with Red Dot on Chart for "High Risk" for falls and will use "Red Slipper" Protocol.

C. Rural Health Care Clinics: The Clinic personnel will verify patient Identification using at least 2 patient identifiers before providing care, treatment and services. (Refer to Policy #: RHC-0044).

D. Outpatient Rehabilitation Services: Patients receiving outpatient rehabilitation services shall be identified by comparing two patient identifiers:

1) A patient identification card, such as drivers license, school ID card, library card, etc.

2) A physician order and/or patient requisition that contains patient name and date of birth.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient Identification (Known and Unknown Individuals)

Descriptive Type: Revised

Document Number: 10-1126

Attachments: None

Author: Julie Gresham (reviewed by Jonah Miller, Lionel Machado, Patti McCowan, Pat Mathewson, Pat Speers and Sharon Fong

Typist: Julie Gresham

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Patient Safety Committee	N/A~~05/01/14~~	Date change only
MEC	N/A~~05/14/14~~	Date change only
Board of Directors	N/A~~05/28/14~~	

Effective Date: 05/29/14

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Conflict of Interest - Patients

I. POLICY:

To assure care provided to patients will not be dependent upon personal, financial or fiduciary relationships or responsibilities, all identified conflicts of interest will be addressed. A conflict of interest may take overt or covert forms, and can represent many situations. However, it is generally understood that a conflict of interest constitutes a situation when the organization as a whole or individual representatives of the organization, has competing professional or personal obligations or personal or financial interests that would make it difficult for the organization or the individual(s) to fairly fulfill the mission, vision and values of the institution. In general, conflicts of interest relate to the potential for self-gain usually, but not always, of a fiscal nature. Potential for self-gain can serve to undermine the judgment or objectivity of licensed independent practitioners, administrators, employees, consultants and designated contractors such that their mission and dedication to the values and activities of this healthcare institution are compromised. Therefore it is required that any contractual arrangement, partnership, agreement or fiduciary relationship (including employment) entered into by Tulare Local Healthcare District and any other party that will affect the mission, vision or values of the district~~hospital~~, must respect and abide by the policies, procedures and directives of Tulare Local Healthcare District.

II. PROCEDURE:

A. Tulare Local Healthcare District accepts the responsibility for the provision of optimum care and services to its patient population, and therefore must protect the integrity of clinical decision making, management of disease processes and the provision of treatment and care to all patients.

B. Tulare Local Healthcare District will disclose any existing or potential conflicts of interest for those who provide care, treatment and services as well as management and governance activities.

Effective Date: ~~12/2/04~~

Approved:

Medical Executive Comm.: ~~11/10/04~~

(10) Administration
General:
Conflict of Interest - Patients
10-1127

Board of Directors: 12/1/04

C. Tulare Local Healthcare District will routinely review our existing relationship and ~~our~~ staff's relationships~~,~~ with other care providers, educational institutions and payers to ensure that all relationships are within law and regulation and to identify and determine if conflicts of interest exist.

D. All conflicts of interest, including potential conflicts of interest, will be researched and addressed in an effort to resolve the conflict of interest abiding by state and federal legal regulations and requirements.

E. Regardless of any fiduciary relationship with any healthcare provider (licensed clinical practitioner, vendor, educational institution, payer, outside resource agency, etc.), the district~~hospital~~ and its representative staff (including medical staff), will strive to provide optimum care to patients following appropriate utilization of resources standards. Care provided to patients will not be dependent upon financial relationships or fiduciary responsibilities.

F. Tests, studies, treatments or procedures deemed usual and routine in the diagnosis, management or treatment of disease processes; as standard in the healthcare community, will not be withheld from any patient (unless the patient exercises his/her patient right to refuse treatment).

G. Any healthcare provider who feels there is a conflict of interest in patient management and their relationship with the facility, must contact administration and notify the Chief Executive Officer immediately.

1. Discussion at the administrative level will be initiated, whereby problem resolution will be the primary goal. In the interim, the chief of the service/department with jurisdiction over the healthcare provider, will arrange for coverage of the patient; until resolution has been reached.

2. If resolution cannot be reached at the administrative level, the matter will be forwarded to an executive committee of the Governing Body, who will meet as soon as practicable, however no later than one week after notification of issue. The Governing Body's primary purpose is to assure that optimum patient care and treatment is provided, regardless of fiduciary relationships, while maintaining a fair and just review of all circumstances surrounding the issue. The determination of the Governing Body will be final.

H No contract or transaction entered into by the corporation known as Tulare Local Healthcare District, shall be affected by the fact that a director, member or officer of the corporation was personally interested in the contract or transaction or was personally interested in or a director or officer of a corporation that was personally interested in the contract or transaction.

I. A member of the Governing Body or a member of a committee, when called upon to cast a vote for or against a matter which personally involves such individual, shall disclose himself/herself ineligible to vote on the grounds of conflict of interest. In cases where conflict of interest is not clearly apparent, or when such conflict is not declared by a person who in the opinion of other members has potential conflict, the conflict of interest issue may be brought before the body who will vote on such issue to determine whether or not a conflict of interest exists.

J. Should there become known, at any time, a conflict of interest between any member of the Governing Body, medical staff, district~~hospital~~ personnel or other healthcare providers and the district~~hospital~~ or any of its agents, the individual(s) may excuse himself/herself from discussions and/or determinations with the identified healthcare provider(s).

K. All members of the Governing Body, medical staff and hospital personnel have the responsibility and obligation, if there is such a time as it is discovered; that due to a fiduciary relationship, care of any patient may be compromised or may not be delivered within the known standard of care; to notify the Chief Executive Officer of Tulare Local Healthcare District Hospital immediately upon identification of this issue.

Questions concerning any aspects of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Descriptive Name: Conflict of Interest - Patients

Descriptive Type: ~~New Policy~~Revised

Document Number: 10-1127

Attachments: None

Author: ~~Tina Anthony~~Ena Menezes/Andrea Carrasco

Typist: ~~Julie Gresham~~Carol Bradford

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Utilization Review Committee	N/A~~10/28/04~~	Date change only
MEC	N/A~~11/10/04~~	Date change only
Board of Directors	~~12/01/04~~	

Effective Date: ~~11/02/04~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE LOCAL HEALTHCARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Facility Planning for Construction or Remodeling

PURPOSE:

It is the policy of Tulare Local Health Care District to ensure that a safe environment is maintained during all construction or remodeling activities, and that all applicable Department of Healthcare Services (DHS) and Office of Statewide Health Planning and Development (OSHPD) requirements, Occupational Safety and Health Administration (OSHA) and National Fire Protection Association (NFPA) codes, and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Interim Life Safety Measures (ILSM) standards are met.

POLICY:

All construction, remodeling, renovation or installation activities will be reviewed and approved by the Facility Planning Team prior to initiation, using the following guidelines:

A. Facility Planning Team
The Facility Planning Team is responsible for the review and planning of all construction and remodeling projects, and the management of all inspection processes required for the safe completion and regulatory compliance of those projects.

1. Projects include, but are not limited too,
    a. New construction
    b. Remodel of existing space, including changes to any structural aspect (walls, doors, etc), removal and/or installation of fixed equipment, cabinetry, etc.
    c. All work involving electrical, wiring, HVAC or plumbing systems.
    d. Vendor installations of fixed equipment.
    e. Renovation work including paint, flooring, window treatments, etc.

Effective Date: (10) Administration General: Facility Planning for Construction or Remodeling 10-1129

APPROVED:

Medical Executive Comm.:

Board of Directors:

2. Facilities Team members:
   a. Chief Operations Officer
   b. Director of Engineering
   c. Infection Control Nurse
   d. Hospital contracted Architect of Record
   e. Hospital contracted Inspector of Record (IOR) for OSHPD
   f. Additional members as needed (hospital Fire Marshall, consultants, Inspectors, etc.)

PROCESS

A. Project Requests

Department managers will submit construction or remodeling requests to the committee, either through written request or attendance at the Facility Planning Team meeting, using the following guidelines:

1. Requests for review are to be made during the consideration phase of a project or purchase to allow adequate time for review, site visit, planning for supplemental needs (wiring, outlets, etc), and OSHPD design and approval processes (if required).

2. Projects will be prioritized based on patient necessity, timing, departmental need, regulatory requirements and availability of resources.

B. Project Review

All requests will be reviewed by the team in a timely manner. The Project Review form will be available on the "Read Only" drive for applicable staff. Review will include documentation of the following:

1. Scope of work: Including description of the work to be performed, trades or services involved, length of project, and assigned staff.

2. Classification of work: All projects will be categorized as one of the following:

   a. "OSHPD": large projects requiring architectural and engineering documents, full review/approval at the state level, and OSHPD inspection/approval during construction. These projects usually require Board of Directors approval.

   b. "Local": small projects requiring more basic architectural documents (anchor details, simple door installation details, etc), and inspection/approval by local OSHPD authorities. These projects are

usually performed under the OSHPD Annual Permit, and may or may not be capital projects.

c. "In-House": small projects requiring no architectural documents (window treatments, flooring replacement, etc), and inspected/approved by facility or consulting staff.

d. "City"**:** projects occurring on the hospital campus or hospital owned properties requiring City of Tulare Planning Department review, permit, inspection and approval (i.e. roofing, electrical, etc.)

3. Project Details: including assigned project leader and inspector, contact names and numbers, vendors, suppliers, equipment specifications, installation guidelines, timelines for completion, etc.

4. Applicable Regulatory Requirements/Agencies: reference to all applicable regulatory requirements or agencies having jurisdiction will be documented.

5. Risk Assessment: review of the project will include completion of the "Pre-Construction Assessment/Interventions" form (form is available in the Project Managers office and Infection Control Office), covering the following:

a. Infection Control Risk Assessment and Plan (performed per hospital policy 20-8023, "Infection Control Risk Assessment for Construction and/or Renovation").

b. Interim Life Safety Measures (performed per hospital policy 22-1008 Interim Life Safety Measures)

c. Noise Generation

d. Air Quality

e. Vibration Issues

f. Utility Issues

g. Fire Drill/Egress logs

C. Project Management

All projects, regardless of scope, will be assigned a project leader who will be responsible for oversight of the project as related to:

1. Hazardous Surveillance per hospital policy 22-1008 Interim Life Safety Measures.

2. Construction Site Inspections: if required, per hospital policy 22-1008 Interim Life Safety Measures).

3. Daily Infection Control Monitoring: if required, per hospital policy 20-8023, "Infection Control Risk Assessment for Construction and/or Renovation").

4. Project Closeout: documentation of compliance with all regulatory requirements and completion of all required interventions identified before and during construction. Forms will be available in the Project Managers office.

D. Project Records

Records of all reviewed and completed projects will be kept in the office of the Director of Engineering.

APPLICABLE REGULATIONS & STANDARDS:

- Joint Commission Life Safety
- National Fire Protection Agency Life Safety Code
- Occupational Safety and Health Administration
- Office of Statewide Health Planning and Development

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Facility Planning for Construction or Remodeling

Descriptive Type: Revised

Document Number: 10-1129

Attachments: Available in Projects Managers Office and Infection Control

Author: Lionel Machado

Typist: Carol Bradford

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Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Infection Control Comm.	N/A.	Date change only
MEC	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Board of Directors, Finance Department

FROM: Administration

SUBJECT: Expense and Use of Public Resources by Directors

PURPOSE:

This policy provides guidelines for the reimbursement of certain actual, necessary and reasonable expenses incurred on behalf of Tulare Local Health Care District (the District) by members of the District's Board of Directors (the "Board") in the performance of their official duties. Particularly, this policy is intended to ensure District compliance with the provisions of AB 1234, state and federal law which govern the reimbursement of actual and necessary expenses incurred by members of the governing body of local agencies in the performance of official duties.

I. Compensation for Attendance at Conferences and Meetings

Notwithstanding the provisions of this policy regarding reimbursement for actual and necessary travel, lodging and meal expenses incurred as a consequence of attending educational conferences, seminars and workshops approved by the Board, members of the Board ("Director" or collectively "Directors") will not be compensated for attendance at such meetings, or meetings of the Board or District committees.

II. Authorized Director Expenses

2.01 **General**

Each Director is encouraged to participate in those activities and organizations that in the judgment of the Board further the interest of the District. Expenses incurred in connection with the following types of activities generally constitute authorized expenses, assuming all other requirements of this policy are met:

a. Communicating with representatives of regional, state and national government on policy and related matters concerning the District;

b. Attending educational conferences, seminars and workshops approved by the Board pursuant to Section III of this policy which

are intended to Improve Directors' skill and knowledge in the performance of their official duties;

c. Participating in local, regional, state and national organizations whose activities affect the District's interest; and

d. Implementing a District-approved strategy for attracting and retaining medical professionals and medical services to the District.

2.02 **Attendance at Conferences, Seminars and Workshops**

Attendance at various educational or instructive conferences, seminars and workshops designed to increase and develop the knowledge and skill of the Directors with respect to their official duties to the District is a recognized benefit to the District. At the same time, such activities present an expense to the District, and therefore, require the approval of the Board.

a. **Board Evaluation and Approval**

The Board will evaluate and approve or disapprove request for District funded attendance at educational conferences, seminars and workshops using the following criteria:

1. Appropriateness given the nature and scope of the director's official responsibilities in his or her responsibilities as a direct of the District;

2. Potential to enhance the director's knowledge, skill, understanding and capabilities related to the scope of his or her professional and departmental responsibilities as a director;

3. Availability of funds based on the balance of the Director's seminar budget or other relevant budgetary information; and

4. Director's previous attendance of similar meetings.

b. **Initiation by Director**

A director desiring to attend an educational conference, seminar or workshop shall first present the matter to the Board. With the Board's approval, the Director shall then submit the appropriate request signed

by an officer or fellow board member and registration forms and send such to the finance department for payment.

c. **Responsibility to Share and Report**

Approval to attend conferences, seminars, workshops and other meetings does at all times require the Director to share the information learned arising out of his or her attendance with the Board, doctors, medical staff or other employees of the District, and report such information to the public as required by law and Section VI of this policy.

2.03 **Expenses Requiring Prior Approval**

All expenses not set forth under Paragraph 2.01, above, require prior approval of the Board. Expenses requiring prior Board approval include, but are not limited to:

a. **Expenses in Excess of Annual Limits**

To the extent the Board establishes budgetary limitations on the amount of total expenses an individual Director may incur in a given year, the portion of the business expenses which exceed the established annual limit shall not be reimbursed unless approved in advance or subsequently ratified by the Board. In no event, shall the establishment or existence of an annual budget relieve a Director from filing an expense report, or preclude the Board from making a determination that each expense complies with this policy, the law, and other ethical considerations.

b. **International and Out of State Travel**

Expenses incurred pursuant to international or out of state travel shall not be reimbursed unless approved in advance or subsequently ratified by the Board.

c. **Excessive Expenses**

Expenses exceeding $1500.00 per trip shall not be reimbursed unless approved in advance or subsequently ratified by the Board.

2.04 **Non-Reimbursable Expenses**

Non-reimbursable personal expenses include, but are not limited to:

a. The personal portion of any trip;

b. Political or charitable contributions or events;

c. Family expenses, including partner's expenses when accompanying a Director on District-related business, as well as children or pet-related expenses;

d. Entertaining expenses, including theater, movies (either in-room or at the theater), sporting events (including gym, massage and/or golf-related expenses), or other cultural events;

e. Non-mileage personal automobile expenses, including repairs, traffic citations, insurance or gasoline;

f. Personal losses incurred while on District business. Any questions regarding the propriety of a particular type of expense should be resolved by the Board before the expense is incurred; and

g. Attendance of non-approved workshops, seminars, conferences and other meetings or events whether or not related to the director's service to the District.

III. Cost Control Guidelines

To conserve District resources and keep expenses within community standards for public officials, expenditures should adhere to the following guidelines. Should expenses exceed these guidelines; the cost borne or reimbursed by the District will be limited to the costs that fall within the guidelines. Receipts for all reimbursable costs set forth under this Section III shall be attached to the appropriate expense claim.

3.01 **Transportation**

The most economical mode and class of transportation reasonable consistent with scheduling needs and cargo space requirements must be used, using the most direct and time-efficient route. Directors shall use government and group rates when available.

a. **Airfare**

Airfares shall be paid or reimbursed at coach rates. Airfare claims for higher fare or additional airline charges or fees may be allowed if

accompanied by a full explanation including the facts giving rise to the necessity.

b. **Automobile**

Automobile mileage shall be reimbursed at the maximum allowable per mile rate as established from time to time by the Internal Revenue Service (the "IRS rates"). (See www.irs.gov.). These rates are intended to compensate the driver for gasoline, insurance, maintenance, and other expenses associated with operating the vehicle. This amount does not include bridge and road tolls, which are also reimbursable. The IRS rates will not be paid for rental vehicles; only receipted fuel expenses will be reimbursed.

c. **Car Rental**

Charges for rental vehicles may be reimbursed under this provision if more than one District director is attending an out-of-town conference, and it is determined that sharing a rental vehicle is more economical than other forms of transportation. Selection of an economy class automobile will be deemed economical and reasonable for purposes of reimbursement under this policy. Directors must purchase collision damage waiver when renting an automobile, the cost of which shall be reimbursed. Failure to do so will cause the Director to be liable for any damages.

d. **Taxis and Shuttles**

Taxi or shuttle fares may be reimbursed, including a 15 percent gratuity per fare, when the cost of such fares is equal or less than the combined cost of car rentals, gasoline and parking, or when such transportation is necessary for time-efficiency.

3.02 **Lodging**

Lodging expenses will be reimbursed or paid for when travel on official District business reasonable requires overnight accommodations. No reimbursement claim or request for lodging expenses, however, shall be approved for expenses incurred within the District's service area, except upon the prior approval of the Board.

a. **Seminars, Conferences and Other Meetings**

If such lodging is in connection with a seminar, conference, workshop other meeting, lodging expenses must not exceed the group rate published by the seminar, conference, workshop or meeting sponsor, if such rates are available at the time of booking. If such rates are not available at the time of booking, directors must comply with Paragraph 3.02(b), below.

b. **Other Lodging**

Directors must request government rates when available. If government rates are not available at the time or in a given area, lodging rates that do not exceed the IRS per diem rates for a given area are presumed reasonable and, therefore, reimbursable.

3.03 **Meals**

When traveling on official and authorized business for the District, reimbursable meal expenses and associated gratuities will not exceed the IRS per diem rates for the area in which the meals are occasioned.

3.04 **Telephone, Fax and Cellular**

Directors will be reimbursed for actual and necessary telephone and fax expenses regarding official District business. Telephone bills should identify which calls were made on District business. As for cellular calls, when the Director has a particular number of minutes included in his or her plan, the Director can identify the percentage of call made on public business.

3.05 **Internet**

Directors will not be reimbursed for Internet access connection and/or usage fees away from home while traveling on District business.

3.06 **Airport Parking**

Long-term parking must be used for travel exceeding 24-hours.

IV. Credit Card Use

The District does not issue credit cards to Directors or employees but does maintain an agency credit card for use in making selected District expenditures. District directors may use the District's credit card for such purposes as airfare and lodging reservations by obtaining prior approval. Receipts documenting expenditures made

with the District credit card and compliance with this policy must be submitted within two business days of use.

V. Expense Report Content and Submission Deadline

6.01 General

All District credit cared expenditures and expense reimbursement requests must be submitted on an expense report form provided by the District. Such form shall include the following advisory:

> *All expenses reported on this form must comply with the Districts policies relating to expenses and use of public resources. The information submitted on this form is a public record. Penalties for misusing public resources and violating the District's policies include loss of reimbursement privileges, restitution, civil and criminal penalties as well as additional income tax liability.*

Expense reports must document that the expense in question met the requirements of this policy. For example, if the meeting is with a legislator, the attending Director should explain whose meals were purchased, what issues were discussed and how those relate to the District's adopted legislative positions and priorities.

6.02 Submission and Payment

Directors must submit their expense reports within 30 days of an expense being incurred, accompanied by receipts documenting each expense. Restaurant receipts, in addition any credit card receipts, are also part of the necessary documentation. Inability to provide such documentation in a timely fashion may result in the expense being borne by the Director. Reimbursements will be made on the next appropriate accounts payable check run.

6.03 Audits

All expenses are subject to verification that they comply with this policy.

VI. Reports to the Board

At the following Board meeting, each Director shall briefly report on any Brown Act meetings attended at the District's expense. If multiple officials attended, a joint report may be made. The report may be made orally or in writing.

VII. Compliance with Laws

The District directors must keep in mind that some expenditures may be subject to reporting under the Political Reform Act and other laws. All Agency expenditures are public records subject to disclosure under the Public Records Act.

VIII. Violations of this Policy

Under state law, use of public resources or falsifying expense reports in violation of this policy may result in any or all of the following: (a) loss of reimbursement privileges; (b) a demand for restitution to the District; (c) the District reporting the expenses as income to the Director to state and federal tax authorities; (d) civil penalties of up to $1000 per day and three times the value of resources used, and (e) prosecution for misuse of public resources.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Expense and Use of Public Resources by Directors

Descriptive Type: RevisedNew Policy

Document Number: 10-1130

Attachments: None

Author: Legal Counsel

Typist: Julie GreshamCarol Bradford

Creation Date: 2/18/07

Prev. Dist. Date: None

Revision DateNotes: 02/20/18

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	04/25/07	

Effective Date: 04/26/07

Forward To: Policy Binders – 5 – Post on Intranet

Disposition: Copy and Distribution – Administration

Comments: See also 10-1031.1 Expense Consideration and 10-1031.2 Expense Reimbursement

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Management of Patient Care Contract Services

I. Purpose:

To establish the organization's oversight of care, treatment, and services provided through contractual arrangements to patients, clients, or residents.

II. Definition:

A contractual agreement is a form of written agreement with another organization, group, agency, or individual to provide care, treatment, and/or services on behalf of the organization. Such written agreements may include formal contracts, memorandums of understanding, or letters of agreement, or other written documents.

III. Exclusions:

1. This policy does not apply to contractual arrangements entered into by the organization that are not for patient care, treatment or service. However, contracted entities must still abide with law, regulation, and appropriate accreditation standards. Such contracts include, but are not necessarily limited to:

   A. Administrative services such as billing, marketing, and management consulting.

   B. Supply and environmental support services such as materials management, landscaping, security, and waste management.

IV. Policy:

1. Expectations of Contract Entity:

   A. Contract entities are expected to provide the same level of high-quality care, treatment, and service as that provided directly by the

organization. Such care, treatment, and service shall be provided in a safe and effective manner.

B. Contract entities are also expected to comply with applicable DNV, The Joint Commission accreditation standards, as well as law and regulation. Furthermore, contract entities are expected to recognize that the organization retains overall responsibility and authority for the level of safety and quality of patient care provided.

2. Competence of Contract Entity Staff:

A. Personnel provided by a contract entity are subject to the same expectations for qualifications, orientation, and assessment of competence as staff provided by the organization.

B. For contract entities providing licensed independent practitioners (LIP), the LIP must meet the credentialing and privileging requirements established by the organization and/or its medical staff. If the contract entity is Joint Commission accredited, and provides care, treatment, and service off-site, the organization may do the following:

1. Verify that all LIP who will be providing care, treatment, and services have appropriate privileges (clinical responsibilities) by obtaining a copy of the list of privileges (clinical responsibilities) – or – specify in the written agreement that the contract entity will ensure that all contracted services provided by LIP will be within the scope of their privileges (clinical responsibilities).

2. Hospitals using the services of LIP from a Joint Commission or DNV accredited ambulatory care organization through a telemedical link for interpretive services, the organization may accept the credentialing and privileging decisions of that ambulatory care organization only after confirming that those decisions are made using the processes described in DNV and/or the Joint Commission's hospital accreditation standards.

3. Contracted Entities Accredited By The Joint Commission/DNV:

A. Contract entities that are accredited by the Joint Commission/DNV shall provide care, treatment, and services that are included within

the scope of their accreditation and/or certification. The contract entity's policies and practices must meet the same requirements as the organization in the provision of its care, treatment, and service.

4. Contractual Agreements:
   A. There shall be a written contractual agreement with each contract entity providing care, treatment, and service. The expectations of the contract entity, as well as the nature and scope of care, treatment, and services to be provided shall form part of the contractual agreement.

   B. Clinical leaders and medical staff shall be afforded an opportunity to provide advice about the sources of clinical services that are to be provided through contractual agreement.

   C. If a contract is~~t~~ time limited and ~~it~~ intended to be renewed it should be renewed prior to the expiration date. If, however, the contract is not renewed by the listed expiration date, it shall – by this policy – be considered current, binding, and in full force until such time as it is renewed.

   D. When contractual agreements are renegotiated or terminated, the organization will assure that continuity of patient care is maintained.

   E. Contractual agreements must be approved by at least the applicable administrative department director, and/or others if specified in this or other organization policy.

5. Evaluation of Contract Entities:

   A. Contracted entities shall be evaluated in relation to the expectations placed upon them by the organization. In general, evaluations should be conducted on an annual basis; however longer or shorter time frames may be allowed based on the history and performance level of the contract entity.

   B. In evaluating expectations, the organization may review any, all, or a combination of, the following sources of information:

      1. Information about the contract entity's Joint Commission accreditation/DNV and/or certification status

      2. Direct observation of patient care by contract entity staff

3. Audits of medical (clinical) record documentation by contract entity staff

4. Review of incident reports

5. Review of periodic reports submitted by the contract entity on the quality and safety of care, treatment, and services provided

6. Data that addresses the efficacy of the contract entity

7. Review of performance reports based on indicators required in the contractual agreement

8. Input from patients, families, and/or organization staff

9. Input from clinical leaders and the medical staff

10. Review of patient satisfaction data

11. Review of the results of risk management activities

12. Other pertinent sources of information

C. If a contract entity does not meet expectations, the action should be taken which may include but not necessarily be limited to:

1. Increasing the monitoring of the contract entity

2. Providing consultation or training to the contract entity

3. Renegotiating the terms of the contract

4. Applying penalties or other remedies

5. Terminating the contract

D. Reference and contract laboratory services shall meet the federal and regulations for clinical laboratories and maintain evidence of the same.

E. The results of the evaluation should be submitted to the appropriate clinical leaders and medical staff for review, and input.

References:
Joint Commission Standard LD.04.03.09

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Tulare Local Health Care District ~~Hospital~~
Review of Contract Service

Name of Service: _____

Date of Review: _____ **Name / Title of Reviewer:** _____

Nature of Service (describe):
_____

Evaluation / Sources of Information **Check the boxes next to the information source(s) utilized. It is not necessary to utilize every information source listed, but at least two should be utilized. For each source checked, note if expectation were met or not in the appropriate column**	**Met Expectation**	**Did Not Meet Expectation**
☐ Information about the contract entity's Joint Commission accreditation and/or certification status		
☐ Direct observation of patient care by contract entity staff		
☐ Audits of medical (clinical) record documentation by contract entity staff		
☐ Review of incident reports		
☐ Review of periodic reports submitted by the contract entity on the quality and safety of care, treatment, and services provided		
☐ Data that addresses the efficacy of the contract entity		
☐ Review of performance reports based on indicators required in the contractual agreement		
☐ Input from patients, families, and/or organization staff		
☐ Input from clinical leaders and the medical staff		
☐ Review of patient satisfaction data		
☐ Review of the results of risk management activities		
☐ Other:		

Comments

_____
_____
_____

Conclusion (check one)

☐ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply:
- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

Input from Clinical and Medical Staff Leadership:

Presented to / reviewed by _____ on _____

Presented to / reviewed by _____ on _____

Descriptive Name: Management of Patient Care Contract Services

Descriptive Type: Revised~~New Policy~~

Document Number: 10-1133

Attachments: Review of Contract Service

Author: ~~Julie Gresham~~

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 11/29/08

Revision Date: 02/05/18

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
MEC	~~12/10/08~~	
Board of Directors	~~01/14/09~~	

Effective Date: ~~01/15/09~~

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Nondiscrimination Policy

Policy:

As a recipient of Federal financial assistance, Tulare Regional Medical Center does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Tulare Regional Medical Center directly or through a contractor or any other entity with which Tulare Regional Medical Center arranges to carry out its programs and activities.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.
In case of questions, please contact:

Provider Name: Tulare Regional Medical Center

~~Officer Contact Person: Julie Gresham, RN Chief Compliance/Quality~~

~~Telephone number: (559) 685-3816~~

~~TDD (Hearing Impaired): (559) 688-6148~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~05/27/10~~ (10) Administration General: Nondiscrimination Policy 10-1134

APPROVED:

Board Of Directors: ~~05/26/10~~

Descriptive Name: Nondiscrimination Policy

Descriptive Type: New Policy

Document Number: 10-1134

Attachments: None

Author: Julie Gresham~~/Andrea Carrasco/Ena Menezes~~

Typist: Julie Gresham/Andrea Carrasco/Ena Menezes

Creation Date: 05/06/10

Revision Date: 02/05/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~05/26/10~~	

Effective Date: ~~05/27/10~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments: Revisions as required by the Department of Health and Human Services, Office for Civil Rights, Washington DC.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

DELETE

TO: All Departments

FROM: Administration

SUBJECT: Auxiliary Aids and Services for Persons with Disabilities

I. POLICY:

A. Tulare Regional Medical Center will take appropriate steps to ensure that patient's with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits. The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. The procedures also apply to, among other types of communication, communication of information contained in important documents, including waivers of rights, consent to treatment forms, financial and insurance benefits forms, etc. All necessary auxiliary aids and services shall be provided without cost to the person being served.

B. All staff will be provided written notice of this policy and procedure, and staff that may have direct contact with individuals with disabilities will be trained in effective communication techniques, including the effective use of interpreters.

II. PROCEDURES:

A. Identification and assessment of need:

1. Tulare Regional Medical Center provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our ***(brochures, handbooks, letters, print/radio, television advertisements, etc.)*** and through notices posted ***(in waiting rooms, lobbies, etc.)***. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

B. Provision of Auxiliary Aids and Services:

1. TRMC shall provide the following services or aids to achieve effective communication with persons with disabilities:

   a. For Persons Who Are Deaf or Hard of Hearing

i. ~~i.~~ For persons who are deaf/hard of hearing and who use sign language as their primary means of communication use the video cam langague line.~~,~~ ~~the Nursing Supervisor or his/her designee or Clinic Supervisor is responsible for arranging for a qualified interpreter when needed. The Nursing Supervisor or his/her designee can be paged at **501-5001**~~. Interpreter services shall be provided by one of the following resources:

ii. Use FOX interpreting only if above not available

FOX interpreting (Visalia, CA)
Office 559-636-3294
Mobile 559-696-9093
Pager 559-749-8714

~~Valley Advocacy and Communication Center (Fresno, CA)~~
~~Service 559-225-3323~~
~~Admin. 559-221-8222~~

ii. If an interpreter from either Fox Interpreting ~~or Valley Advocacy~~ can not provide sign language services, the following Auxiliary Aids shall be used to communicate with the Deaf and/or Hard of Hearing patient/person.:

- Telecommunications Device (TTD) for the Deaf:
- Amplified Handset
- Closed Caption Decoder

iii. Tulare Regional Medical Center utilizes a Telecommunication Device for the Deaf (TDD) for external communication. The telephone number for the TDD is (559) 688-6148.

~~iv. When it is determined by staff that a TDD is needed, the department/clinic site shall contact Nursing Supervisor or~~

~~his/her designee or Clinic Supervisor to obtain the device for use.~~

v. Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and ***after*** an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

NOTE: Children and other residents will *not* be used to interpret, in order to ensure confidentiality of information and accurate communication.

2. For Persons whom are blind or Who Have Low Vision

a. Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision**.**

b. For patients that are deaf or hard of hearing **and** blind, a telecommunications device is available for communicating. The device has Braille capabilities. The deaf/blind person can communicate with another deaf/blind person or with a hearing person. This device is available in the clinics as well as the hospital system. In addition, staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

3. Persons with Speech Impairments

a. To ensure effective communication with persons with speech impairments, staff will contact the Nursing Supervisor/Office or their Supervisor who is responsible to provide the aids and services in a timely manner:

b. Writing materials; TDDs or communication boards are available to assist these patients.

4. Persons with Manual Impairments

a. Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:

b. note-takers; computer-aided transcription services; speaker phones; or other effective methods that help to ensure effective communication by individuals with manual impairments~~. For these and other auxiliary aids and services, staff will contact the Nursing Supervisor, his/her designee via pager 501-5001 or their Clinic Supervisor.~~

III. DOCUMENTATION OF USE OF INTERPRETER OR COMMUNICATION DEVICE

1. Staff is to document the following information in the patient's medical record with each interpreter encounter.

a. Interpreter used.

b. Date and time.

c. Length of interpretation.

d. Document if competent interpreter is not available, alternative method used.

e. Use of any auxiliary communication device.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Auxiliary Aids and Services for Persons with Disabilities

Descriptive Type: New Policy

Document Number: 10-1135

Attachments: None

Author: Julie Gresham/Andrea Carrasco/Ena Menezes

Typist: Julie Gresham

Creation Date: 05/06/10

Revision Date: 02/05/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	05/26/10	

Effective Date: 05/27/10

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments: Revisions as required by the Department of Health and Human Services, Office for Civil Rights, Washington DC.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Discharge Planning

I. POLICY:

A. Scope of Discharge Planning Process:

Effective discharge planning is essential to the continuum of care of each patient. Such planning is vital to maintaining a course of treatment specific to each patient from admission until discharge. If the patients discharge plan is clearly and specifically put into place, than the likelihood for readmission may be prevented.

B. Initiation of Discharge Planning Process:

Discharge planning process shall begin upon admission~~, both on the nursing "Multidisciplinary Daily Activity Flow Sheet".~~

1. Upon admission, the RN will identify in the "Preparation for Discharge" area any needs that may be required.

2. The action may be initiated by Case Management, Discharge Planner, or Social Services in consultation with the nursing staff creating a collaborative effort to develop a comprehensive individualized discharge plan.

3. The above team in addition to the Physician will continue mapping out the discharge plan and adjust according the patients needs and shall become an immediate part of the patient's care plan.

4. Patients ~~-~~will be provided with the opportunity to identify one family caregiver who may assist in post-hospital care. The designated caregiver's information is to be recorded into the patient's medical record. If the patient declines to designate a caregiver, documentation of the declination is to be placed in the patient's medical chart. ~~.~~In the event the

patient is unconscious or otherwise incapacitated upon admittance, the patient will be provided the opportunity to identify the caregiver after the patient recovers consciousness or capacity.

C. Discharge Planning for "High Risk Patient Population":

1. Upon admission the RN, Case Manager, Discharge Planner, Social Worker and the Physician or any of the other collaborative team members may refer potential "High Risk" patients.

   a. "High Risk" may be any of the following, but is not inclusive:

      - Elderly
      - Elderly, living at home alone or confused
      - Multiple co-morbidities
      - Persons with drug/alcohol problems
      - Children with special needs
      - Premature newborns
      - First time mothers of newborns

D. Discharge Planning Evaluations:

1. Evaluations of patient care needs based on prior level of care, current living situation, and who will need to assist with those care needs.

2. Evaluation can be with patient/family or designated care provider.

3. Evaluation will consist of:

   a. Potential level of care upon discharge
   b. Need for Durable Medical Equipment
   c. Follow up care with primary care/specialty physician
   d. Home Health care, PT/OT/SS and nursing care needs
   e. Acute Rehabilitation Services
   f. Skilled Nursing placement either short term or long term
   g. Additional or new medication regimes
   h. Hospice care needs

4. Evaluation can be formal or informal but needs to indicate who is the designated family member or who will be designated care provider upon discharge. Refer to "Durable Power of Attorney for Healthcare" if available.

5. Evaluation will be clearly documented in the Case Management/Social

Services documentation area of the chart and to clearly identify to the collaborative team plan of care.

D. Discharge planning to include Medicare Certified List of Discharge Providers:

1. Provide list of SNF, Hospice, Home Health Agencies in patients/family or care givers the patient's geographical area. (See Policy #12-1020 "Inter-facility Transfer of Nursing Home Patients" for guidelines).

2. Present list to patients needing post-hospital services.

3. The Case Manager/designee of Tulare Regional Medical Center shall document in the discharge note/plan of care that the patient/family or care giver was provided with the list of choices.

4. Patient and/or care giver/family member will sign the "Case Management Patient Discharge Assessment" ~~(Attachment A)~~ as to identify they have reviewed/received such list.

E. Timeliness of Discharge Planning.

1. Hospital Personal collaborating in the discharge plan shall do so in a timely manner as to avoid extended length of stay.

2. Discharge planning starts upon admission and updated as changes in patient condition or social situation dictate during the episode of care.

3. The entire disciplinary team will kept up to date on the discharge plan through documentation including the physician.

4. Referrals will be made as soon as the plan is clearly set in place and not to delay discharge.

5. Family/patient and care provider will be updated in a timely manner as to potential discharge date, discharge plan, and any changes occurring during the stay.

6. The selected vendors shall be notified in appropriate time as to accommodate patient/family and care provider of required services.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Discharge Planning

Descriptive Type: Revised Policy

Document Number: 10-1136

Attachments: None

Author: ~~Shawn Stewart/~~Charlene Dawson

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 08/04/10

Revision Date: ~~10/08/15~~ 02/05/18

Prev. Dist. Date: 08/26/10

Committee Review and Approval:	Approval Date:	Comments:
Utilization Review	~~03/01/16~~	
MEC	~~03/10/16~~	
Board of Directors	~~03/29/16~~	

Effective Date: ~~03/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: GVALHI Club

I. PURPOSE:

The Customer Service Program entitled **Achieving Excellence: *You Make a Difference*** was initiated in August of 2010. The GVALHI (Greet, Value, Ask, Listen, Help, Invite) Club was established to support this endeavor. Our purpose for the GVALHI Club is to keep the spirit alive within TRMC by increasing positive communication with all internal and external customers.

II. GOAL:

To improve patient care and employee satisfaction by reinforcing ideas and commitments of excellent customer service for the betterment of our community and institution.

III. COMMITTEE STRUCTURE:

Officers are chosen yearly, which include President, Secretary, Treasurer and any others pertinent to the yearly action plans of the committee. All Customer Service Program graduates are invited to be members of the committee.

A. Meetings:

Meetings will be scheduled monthly. Meetings will be announced throughout all departments via mass media, e-mails and communication from department directors.

IV. Recognition of Staff

Individual staff members will be recognized for the exceptional service they provide to our internal and external customers by the GVALHI Club Committee. The Customer Service Awards will include, but are not limited to: gift cards, luncheons,

special recognition, etc. The monthly recognition will be voted upon by the committee after submission of names by the Director of Departments and/or other staff. The Department Director in most cases will be asked to approve the recognition.

V. Community Involvement

The GVALHI Club will work closely with the community by having luncheons with patients after they are discharged. The purpose is to receive feedback on the service we provide and solicit further input to improve our organization's customer service. Feedback will be relayed to the appropriate departments.

VI. GVALHI Projects/Promotions

- Flash Mob
- Hospital Signage
- PBX Announcements
- Telephone lines, "hold" messaging
- Monthly Club Meetings
- Monthly Newsletter
- Customer Service Awards
- Visual Aids displayed throughout Hospital
- Others as determined by the Club

VII. GVALHI Club Budget

Administration will allow $2,000 per year to be used at the discretion of the Club to further their efforts. All monies dispersed will be approved by Club members and noted in the meeting minutes. These funds will be distributed to persons and projects supporting the goals of the Club. All monies dispersed from the budget will be noted and accounted for by the Club Treasurer.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: GVALHI Club

Descriptive Type: ~~New~~Revised Policy

Document Number: 10-1138

Attachments: None

Author: Teresa Berbereia/Kim Hughes

Typist: Teresa Berbereia and Gillian Busch

Creation Date: August 2011

Revised Date: 4/24/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
GVALHI Club	~~09/30/11~~N/A	Date change only
Board of Directors	~~12/07/11~~	

Effective Date: ~~12/08/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: ADMINISTRATION

SUBJECT: Animal Assisted Therapy Program

I. PURPOSE:

To establish standard procedures for Animal Assisted Therapy at Tulare Regional Medical Center.

The objective of Animal Assisted Therapy is to provide visits to all patients who meet medical and service criteria and who desire such a visit.

II. POLICY:

A. The physical, psychological and emotional benefits of animal interaction for patients who are hospitalized are well documented in the literature. Populations that have especially benefited from this interaction include children. People often see animals as their friends. Animals offer unconditional love and acceptance. Animal Assisted Therapy visits help promote a sense of normalcy to counteract the foreign and often frightening experience that hospitalization can create. Additionally, TRMC is committed to providing a patient-friendly environment and enhancing the patient and family experience by utilizing a variety of services including Pet Assisted Therapy visitation. The Pet Assisted Therapy program is provided by Paws 4 Healing, is a Community Partner of Pet Partners®. Paws 4 Healing provides Pet Assisted Therapy Teams and supervises these teams while at TRMC.

B. The program exclusion criteria for Pet Assisted Therapy visitation in all areas of the hospital include: any type of isolation, fear of dogs/cats, allergy to dogs/cats other patient(s) in the room who are allergic to dogs/cats, patients S/P endoprosthetic device during hospitalization of procedure, or a written order by physician specifying “No dog/cat visitation”. Physicians who have concerns regarding dog/cat visitations should contact the Director of Medical-Surgical Units and/or the VP of Human Resources.

Effective Date: ~~04/23/15~~

Approved:

Medical Executive Comm.: ~~04/08/15~~

Board of Directors: ~~04/22/15~~

(10) Administration General:
Animal Assisted Therapy Program
10-1139

III. ADDITIONAL UNIT/AREA AND SERVICE-SPECIFIC EXCLUSIONS IN PATIENT CARE INCLUDE:

A. Patients with immunosuppression, fever of unknown origin, open wounds or burns, open tracheotomy (unless covered with a cap; ventilator or oxygen source). Patients are screened for appropriate medical conditions, allergies, phobias, skin integrity, personal preferences, and/or other patient aspects of their rehabilitation. Only those patients deemed appropriate and who have given permission, can participate in the Pet Assisted Therapy. Dialysis exclusions pertain to HIV+ and hepatitis patients.

B. Dog/cat allergies will be ascertained from patients during admission assessment. Information regarding allergies or visitation will be documented in the Condition Alert section of the medical record. The admitting nurse is responsible for documenting “no dog/cat visitation” on nursing care plan indicating the reason for restriction.

IV. INFECTION CONTROL REQUIREMENT SPECIFIC TO DOGS/CATS ARE:

A. Health screening from veterinarian as required by “Pet Partners®” and or Paws 4 Healing.

B. Rabies vaccination as required by County laws.

C. Fecal exam as required by “Pet Partners®” and or Paws 4 Healing.

D. Absence of oral and skin lesions.

E. Absence of acute illness, including but not limited to; vomiting, diarrhea, sneezing, coughing, dermatophytes, or sarcoptic mange.

F. Development of any signs of illness or behavior changes prevents dogs/cats from participation in the program unless evaluated and cleared by a veterinarian.

G. The dog/cat must be bathed-groomed within 24 hours of visiting the hospital. The nails must be trimmed and teeth cleaned; eyes and ears must also be cleaned.

H. Flea control is required. No flea collars, flea shampoo, flea dips, or powdered substances may be used.

V. INFECTION CONTROL REQUIREMENT SPECIFIC TO DOGS/CATS HANDLERS AND STAFF:

A. Ensure the patient’s hands are sanitized with hand sanitizer/or washed before and after each visit.

B. Place clean sheet/towel on patient's bed if visit takes place on bed.

C. NEVER take a dog/cat into a room with any type of isolation sign.

D. ALL staff must wash/or hand sanitize their hands before and after petting a dog/cat.

VI HOUSEKEEPING AND SANITATION PRACTICES INCLUDE GUIDELINES ON THE FOLLOWING SITUATIONS:

A. If the dog/cat defecates, urinates or vomits, the handler will dispose of waste and disinfect area. If any of those occur on carpet, housekeeping will also be notified.

B. If patient bedding or patient becomes soiled, nursing assistance will be requested. All dirty linens will be disposed of in the linen cart. Wastes will be disposed of in the trash.

VII. HANDLER RESPONSIBILITIES INCLUDE:

A. Checking in at the Nursing Station.

B. Handler and dog/cat must wear the TRMC badge at all times unless pre-arraigned.

C. Handlers must abide by all rules and regulations of TRMC

D. Handlers must obtain a list of patients to visit from the charge nurse and review for special concerns

E. Handlers must notify the nursing staff of any unanticipated response or occurrence that may occur during a visitation

VIII. ADDITIONAL HANDLER REQUIREMENTS:

A. In addition to meeting "Pet Partners®" requirements for a Complex rating and further screening, training and probationary period with Paws 4 Healing

B. TRMC requires:

1. TB testing

2. Background check

3. Yearly TRMC Volunteer Orientations

C. Paws 4 Healing a non-profit animal assisted therapy program (an IRS section 501 (c) (3) corporation) has agreed to provide Pet Assisted Therapy to

TRMC. The program has been established to help ill and disabled patients cope with their hospitalization and to aid in their rehabilitation. Instructors from "Pet Partners®" will do all the training of handlers. Only dogs/cats who have acquired a complex rating from "Pet Partners®"/Paws 4 Healing will be allowed to visit at TRMC.

IX. PAWS 4 HEALING HAS THE FOLLOWING RESPONSIBILITIES:

A. Ensure dogs/cats meet all medical criteria as required by "Pet Partners®"

B. Ensure dogs/cats meet performance and behavior criteria established by "Pet Partners®" by bi-annual team evaluations.

C. Ensure that handler dog/cat teams continue to meet all requirements for ongoing participation in the Paws 4 Healing program at TRMC and provide documentation to that effect as required.

D. Health exams for dogs/cats are kept up as required by "Pet Partners®".

E. Comply with schedules.

F. Adhere to components of Paws 4 Healing's agreement with TRMC.

X. PROCEDURE:

A. General Visit Procedure Guidelines:

1. Staff member assigned will accompany Pet Partners® on visits to help with hand sanitizing and towels/sheets.

2. Dog/cat scheduled at specific times and days of the week for each designated in-patient unit.

3. Staff member assigned will have a list of all patients eligible for a dog/cat visit one hour prior to the scheduled visit and make list readily available for dog/cat handler to pick up when arriving on the unit.

4. Staff member assigned will write special concerns on the list such as "no dog/cat on bed".

5. Staff member assigned will ensure that all patients in multi-bed rooms have no known allergies to dogs/cats.

6. If one of the patients/relatives/visitors in the room does not want a dog/cat visit, the curtain will be closed between patients. If the restriction is due to allergies, the non-allergic patient can be encouraged and assisted, as necessary, to come out of the room for the dog/cat visitation, if possible.

7. Dog/cat handlers will knock prior to entering a patient's room and ask if the patient would like a visit with the dog/cat. Handlers must receive approval before entering a room.

B. Staff Member Assigned:

1. Pre-screen patients

2. Notify patient and RN of dog/cat visitation one hour prior to visit

C. Bedside Nurse Responsibility:

1. Review exclusion criteria list

2. Maintain patient safety at all times

D. Dialysis Coordinator Nurse/and Nurse Responsibility:

1. Coordinator nurse will pre-screen patients eligible for dog/cat visit

2. Review exclusions criteria

3. Dialysis nurse adjust equipment and line so that they are not accessible to dog/cat

4. Maintain patient safety at all times

E. Rehabilitation Therapist (s) Responsibility:

1. Therapist will review exclusion criteria

2. List all patients and therapist name in one of the time slots on the Paws 4 Healing Animal Assisted Therapy sheet

Tulare Regional Medical Center, its Medical Staff, Staff, Administration and Governance all recognize the inherent importance visitation plays in a patient's comfort and/or recovery. At the same time, on occasion limitations on visitation up to and including restricting visitation consistent with the patient's wishes. As such, the attending physician and nurse have a right to exempt provisions of this visitation policy as necessary to perform essential duties in the pursuit of patient care. This right to exempt shall not be applied arbitrarily, capriciously or indiscriminately.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Animal Assisted Therapy Program

Descriptive Type: Revised Policy

Document Number: 10-1139

Attachments: None

Author: ~~Tana Bennett & Jean Vafeades, Paws 4 Healing~~ Tana Bennett/Jean Vafeades'Paws #4 healing~~Andrea/Ena~~

Typist: Andrea Carrasco/Ena Menezes~~Melissa Arend~~

Creation Date: 04/04/12

Revision Date: ~~02/18/15~~ 02/08/18

Prev. Dist. Date: 04/26/12

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~04/08/15~~	
Board of Directors	~~04/22/15~~	

Effective Date: ~~04/23/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Business Services, Clinical Support Services

FROM: Administration

SUBJECT: Third-Party Audits of Hospital Bills

Except to the extent that any provision in an existing agreement between Tulare Local Health Care District and any third party payor expressly conflicts with this policy or its application, Tulare Local Health Care District will cooperate with any third-party audits of hospital bills within the parameters defined in this policy. If any provision of any such agreement between Tulare Local Health Care District and any third party payor expressly conflicts with this policy or its application, the agreement provision shall govern over the conflicting policy provision, but the remainder of this policy will otherwise apply. Application of this policy to other persons or circumstances shall not be affected thereby.

When a third-party payor wishes to audit a hospital bill, the payor or its designee shall contact Administration in writing to arrange a suitable time and date to perform the audit. The hospital requires a minimum of 45 days to set up the appointment. The letter shall contain the following minimum information:

1. Patient name
2. Patient account (medical record) number
3. Dates of service
4. Reason for the audit
5. Name of the payor, which authorized the audit
6. Name of the company performing the audit, if not the payor
7. Name of the individual who will perform the audit
8. A check in the amount of $15 per chart in accordance with authorization for release of information policies and procedures to cover the cost of accommodating the audit.

Before the hospital grants permission for the audit, the payor must agree to go ahead and pay its regular benefits on the account. The hospital agrees in turn to promptly refund any agreed-upon overpayment as a result of the audit unless significant other accounts remain unpaid by the payor in which case credits may be applied to such accounts. The hospital will have 45 days to respond to the auditor findings prior to such refund occurring and refund will only occur if the hospital agrees with the auditor findings.

Board of Directors:

The auditor may review the bill to identify services and supplies: (1) billed but not ordered, (2) ordered but not billed, (3) duplicated, (4) not charged, or (5) billed for the incorrect amount. **It is completely inappropriate for the auditor to evaluate the reasonableness of the rates and prices for services and supplies billed.** The auditor may not attempt to disallow or discount charges based upon any type of "usual and customary" re-pricing scheme.

The issue of medical necessity of services shall not be included in the scope of the audit. Any service provided under physician orders shall be deemed billable to the patient or his/her insurance plan. Questions about medical judgment shall not be addressed to hospital staff members.

The auditor shall recognize that documentation for services provided to the patient may exist in records other than the patient's medical chart. Although the medical chart documents clinical data on diagnosis, treatment, and outcome, it does not intend to explicitly document each and every charge on the patient's bill. Process protocols in which use of specific services and supplies are implicit should be accepted as evidence that charges are legitimate.

The auditor must also provide findings of unbilled (lost) charges. Tulare Local Health Care District will expect all unbilled charges to be applied to the agreed-upon overcharges, if any, in the final reconciliation of the account. If desired, another bill for itemization of previously unbilled charges will be submitted to the payor.

The auditor shall present a written final report of audit findings to the hospital, or its designee, for review; the findings will be formally accepted, or contested, by line item. The hospital must be permitted to submit additional documentation to resolve contested findings.

Patients whose bills are not protected by a PPO or similar contract, are ultimately responsible for payment of their hospital bills. In cases where the payor fails to resolve audit disputes in a timely fashion, or otherwise unnecessarily delays payment of a claim, the hospital will look to the patient for satisfaction of the unpaid balance.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Third-Party Audits of Hospital Bills

Descriptive Type: Revised Policy

Document Number: 11-1004

Attachments: None

Author: Lucy Reinche

Typist: Andrea Carrasco/Ena Menezes

Creation Date: 10/29/04

Revision Date: 02/08/18

Prev. Dist. Date: 7/25/01

Committee Review and Approval:	Approval Date:	Comments:
Legal Counsel	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration
Board approved copy to Legal Counsel

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : All Departments

FROM : Administration

SUBJECT: Petty Cash Policy

The purpose of this policy is to establish the responsibilities, controls and processes for establishing, maintaining, and reconciling petty cash accounts.

A petty cash fund shall be established and maintained in the cashier's office for reimbursement of low-dollar-value, one-time purchases that could not reasonably be processed via the standard purchase order process (examples given below.) Access to the fund is restricted to authorized cashier personnel. The fund shall be stored in the hospital safe.

The petty cash fund is not to be confused with the numerous change funds throughout the hospital. The change funds shall not be used for any purpose other than receiving payments from patients and other customers. In an exceptional circumstance after business hours the house supervisor may authorize a change fund to be used for petty cash reimbursement, as long as the transaction meets the petty cash definitions.

The petty cash fund shall not exceed $200. All activity in the petty cash account must be documented in the Petty Cash Log. Receipts must be attached to the log in compliance with documentation requirements. The petty cash account shall be reconciled monthly.

As part of the hospital's internal control structure and process, conflicting duties and responsibilities are segregated when possible within the department. This includes, but is not limited to, the following duties or responsibilities involving petty cash:

1. Replenishment of petty cash shall be requested by the cashier supervisor, and the cash replenished by the accounts payable assistant as authorized by the controller.
2. The designated person in the cashiering department must track the petty cash activity.
3. The patient accounting director shall review the month end Petty Cash Log and sign in approval before submitting to finance for replenishment.
4. The petty cash count shall be performed by a person independent of the individual who is the custodian of the petty cash that maintains the log for the activity in the account.

Effective Date:

Approved:

Board of Directors:

(11) Fiscal & Business General:
Petty Cash Reimbursement
11-1008

Petty Cash Transactions

Generally, petty cash transactions shall be for small dollar amounts not exceeding $20. Amounts exceeding this threshold shall be processed with an AP check.

Each transaction must be documented in the Petty Cash Log. The requesting party must provide a valid receipt, legibly signed by the department manager. The receipt must contain the appropriate general ledger account number for expensing.

The following transactions are prohibited from petty cash:

- Employee reimbursements for supply purchases that could otherwise be made via the standard purchasing process
- Employee wages or commissions
- Payments to vendors over $20
- Patient refunds/ Member refunds

The following are examples of potentially acceptable transactions:

- Emergency food service purchases that can't be made on the grocery purchasing card
- Reimbursement to a visitor for a malfunctioning vending machine
- Emergency purchases made by Materials Management requiring cash

Employees deviating from this policy's guidelines are subject to denial of reimbursement.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Petty Cash Reimbursement

Descriptive Type: Revised

Document Number: 11-1008

Attachments: Sample Petty Cash Log

Author: Delbert Bryant

Typist: Ena Menezes/Andrea Carrasco

Creation Date: 4/14/08

Revision Date: 02/08/18

Prev. Dist. Date: 1/22/03

Committee Review and Approval	Approval Date:	Comments:
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Capitalization Policy and Capital Equipment Purchase Request

DEFINITIONS

1. **Fixed Assets:** Land, buildings, and equipment purchased by or donated to the hospital, which by nature are relatively expensive, and have an extensive life. Included are significant alterations and renovations that materially improve or extend the life of the assets. This does not include normal repair or maintenance and modernization to maintain the present life of the assets.

2. **Depreciable Assets:** Any fixed asset, excluding land, with a unit cost of five thousand dollars ($5,000.00) or more **AND** a minimum useful life of one (2) years.

3. **Plant, Property & Equipment:** Alternative term for fixed assets.

   Land: Real property, including the cost of off-site sewer and water lines, public utility, charges for servicing the land, governmental assessments for street paving and sewers, the cost of permanent roadways and of grading of a non-depreciable nature, the cost of curbs and of sidewalks whose replacement is not the responsibility of the hospital, as well as other land expenditures of a non-depreciable nature. Unlike buildings and equipment, land does not deteriorate with use or with the passage of time, therefore, no depreciation is accumulated.

4. **Land Improvements:** Includes the cost of on-site sewer and water lines; paving of roadways, parking lots, curbs, and sidewalks (if replacement is the responsibility of the hospital); as well as the cost of shrubbery, fences, and walls.

5. **Buildings & Improvements:** Included are all architectural, consulting, and legal fees related to the acquisition or construction of buildings. Interest paid for construction financing is a cost of the building and is included in this account. Fixed equipment is also charged to this account and has the following general characteristics: (1) affixed to the building, not subject to transfer or removal, (2) a life or more than three years, but less than that of the building to which it is affixed, (3) used in hospital operations.

6. **Major Movable Equipment:** Has the following general characteristics: (1) ability to be moved, (2) a more or less fixed location in the building, (3) a unit cost of five thousand dollars or more, (4) a minimum life of one year or more, (5) used in hospital operations.

7. **Minor Equipment:** Has the following general characteristics: (1) location generally not fixed; subject to requisition or use by various departments of the hospital, (2) relatively small size, (3) subject to storeroom control, (4) fairly large number in use, (5) a unit cost of less than $5,000, (6) a useful life may be less than one year, (7) used in hospital operations.

Components with individual unit costs of less than $5,000, but purchased with the intention of combining the components into an overall working system, should be aggregated so that the total system cost is used to determine whether to capitalize.

With the exception of minor equipment, all of the items described shall be budgeted as capital assets. Minor equipment shall be budgeted in the using departments' operational budgets, and expensed with natural classification numbers .4801 (minor medical equipment) and .4901 (minor other equipment).

The attached **"Capital Equipment Purchase Request Form"** must be used when a capital asset purchase is five thousand dollars ($5,000.00) or more per unit. Each department included on this form must accurately complete their section before the purchase can be considered. Each request must be accompanied by a written justification for the expenditure.

Requests are subject to the following approval limits:

1. CFO may approve up to ten thousand dollars ($10,000).
2. CEO may approve up to the amount authorized by the Board of Directors annually.

Instructions for Completion of
Capital Expenditure Request (CER)

Section A: The department name, the requestor, the date of preparation, and description of capital must be completed. The CER and General ledger number are completed by Accounting after Administration has approved.

Section B: Must be completed prior to forwarding to other departments for review. **Three bids should be included with the CER. In the event that 3 bids are not possible, please explain in Section C.**
If there is inadequate room provided on the form in any space requiring a description, explanation, or justification, you may attach additional information to this form and so

note on the form. As applicable, work with Materials Management, Engineering and Information Services managers to complete the necessary information.

Total capital costs Include training and unit cost multiply by the number of units.
Once this section is completed, it should be forwarded to the department manager of the next required section.

Section C: Justification for capital equipment purchase (CER) to be completed by the requestor Director. Explain the reason for acquisition. Is it feasible to repair existing equipment? Is additional equipment needed for increased volume? Is equipment needed for new service?

The purchase of computer terminals, personal computers and printers and/or personal computer software requires approval by the Director of Information Services. (To be completed if applicable.)

Section D: Signature page

Upon completion, the form shall be forwarded to the appropriate division head, who shall insure all applicable sections have been properly completed and signed. Additional review and/or comments may be attached for extra information or justification as desired. After the division head has reviewed the proposal, it shall be forwarded to the CFO for review. If approved, it shall be signed and dated. For requests exceeding one thousand dollars, CEO signature is required.

After the Materials Management Department has ordered the equipment, the following departments shall be notified as appropriate.

1. The ordering department.

2. The Engineering Department if special services are required prior to installation, or if installation is required, so the work can be scheduled.

2. The Finance Department if arrangements need to be completed for financing the equipment purchase.

3. If equipment is reimbursable by another organization, notify the accounting department.

CAPITAL EXPENSE REQUEST (CFR) AND CFR JUSTIFICATION FORMS:

Click on attachment

CER final.xls (36 KB)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Capitalization Policy and Capital Equipment Purchase Request

Descriptive Type: Revised

Document Number: 11-1011

Attachments: Form Included

Author: Delbert Bryant/

Typist: Andrea Carrasco/Ena Menezes

Creation Date: 09/20/12

Revision Date: 02/08/18

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Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

FROM: Administration

SUBJECT: Investment Guidelines

Purpose

To govern the management of surplus monies and provide the required reserves and cash flow. To assure adherence to regulatory requirements.

Policy

The guidelines governing these surplus monies shall be in compliance with Sections 53600-53683 of the Government Code.

Objectives

This policy provides guidelines for the management of Tulare Local Health Care District's Investment portfolio. It is essential that these assets be invested in a high quality portfolio which encompasses:

1. Safety of principal in relationship to the guidelines and market conditions.

2. Meet liquidity needs.

3. Delivers good yield in relationship to the guidelines and market condition.

Liquidity Requirements

The investment portfolio should be constructed so that it can fund the cash requirements of the cash flow forecast. Generally, these liquidity requirements should be met by matching maturities of investments to the cash flow requirement of the District rather than rely on being able to sell securities.

If a circumstance dictates, the cash flow forecast and its associated liquidity requirements may be modified at the discretion of the Chief Executive Officer or Chief Financial Officer, provided that such modifications do not conflict with the other objectives and requirements of the policy.

The District may use the Local Agency Investment Fund (LAIF) offered by the Treasurer of the State of California when it is beneficial to do so. This fund consists of a diversified pool of safe investments providing one-day liquidity at competitive rates.

Investment Guidelines:

1. The guidelines governing these surplus monies shall be in compliance with Sections 53600-5360X of the Government Code. The District's Finance Committee must approve all investments with maturities greater than six years.

2. The Neutral average life of the portfolio shall be between 2 and 4 years.

3. The maximum maturity shall not exceed six (6) years except in certain circumstances as approved by the District Finance Committee or Board of Directors.

4. State law provides that no more than 60% of the portfolio is to be invested in securities maturing beyond five years.

5. Safety shall always be the primary consideration in structuring the portfolio. Safety considerations include market risk, credit risk, and the safekeeping of securities. The following guidelines shall be followed:

   - Market Risk - The risk of loss of principal due to changes in market conditions. Generally, this is a function of the maturity of the security, with longer-term maturity being the most subject to price volatility.

   - Credit Risk - The risk that the institution backing the security held will default. Emphasis will always be on securities of high quality. Holdings are subject to the following limitations:

     A. Quality credits "A" or better are to be utilized in the portfolio as rated by Moodys, S&P, or A.M. Best, as applicable. If, after acquisition, an investment rating should be downgraded below "A", the investment will be liquidated as soon as possible without surrender charges.

     B. Money Market Securities: A-1/P-1/Mig.1 by Moodys and S&P.

6. A broadly diversified portfolio will be maintained with the object of obtaining the highest return with minimal risk to the security of the principal.

7. Realization of capital gains and losses shall be viewed solely in terms of investment merits.

8. Eligible investments (see Exhibit A)

A. Corporate obligations may have maturities no greater than five (5) years and with an "A" or better rating. No more than 30% of the total assets may be invested in this sector.

B. Permitted types of international investments may be made only with firms that are licensed in California.

C. Mortgage-backed securities are to be managed subject to the following:

- Shall be limited to no more than 20% of total assets.
- Primary mortgage –backed investment emphasis is to be in the issues of the Government National Mortgage Association, the Federal Home Loan Corporation and the Federal National Mortgage Corporation.
- The maturity span or average life of Government or Government Agency mortgage-backed securities cannot be Calculated or even properly estimated. As an alternative constraint, the duration (a measure of price volatility) of each issue will be no greater at the time of purchase than that of the current ten-year U.S. Treasury Note.

D. Annuities with six (6) years or less maturities with an "A" or better rated company.

E. Guaranteed Income Certificates with maturities of five (5) years or less with an "A" or better rated company.

F. Commercial paper with an "A" or better rated company organized and operated within the United State and have total assets in excess of $1,500,000,000. No more than 40% of the total assets may be invested in this sector and must not exceed 180-day maturity.

9. Performance measurement – The benchmarks for the portfolio shall be the Lipper Short-Term 1-3 years U.S. Government Fund.

   Lipper Short Term (1-3 Years) U.S Government Fund – invests at least 65% in securities issued or guaranteed by the U.S. Government, its agencies or instrumentality's with average maturities of 3 years or less.

10. Prohibited Investments (see attached code):
    The District will not invest in any investments outlined in the Government Code Section 53601.6 as prohibited. The Finance Committee (Investment Committee) or the Board of Directors must approve exceptions to the above restrictions.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Exhibit A
Example of Eligible Investments

Eligible Investments – Taxable

U.S. Treasury Bills

U.S. Treasury Notes

U.S. Federal Agencies

Guaranteed Income Certificates

Commercial Paper

- U.S. Corporations
- Foreign Corporations
- Custody

Certificates of Deposit/Bankers' Acceptances/Time Deposits

- Obligations of U.S. Banks
- Obligations of foreign banks
- U.S. London

Corporate or Eurobond Obligations

Repurchase Agreements

Floating Rate/Notes

Mortgage-backed Securities

Asset-backed Securities

Single Premium Annuities

Tax-Exempt Investments

- Municipal Bonds
- Municipal Notes
- Municipal Put Securities
- Municipal Commercial Paper/Floaters

Descriptive Name:	Investment Guidelines
Descriptive Type:	Revised
Document Number:	11-1013
Attachments:	None
Author:	Lucy Remchie ~~Lucy Reimche~~~~Andrea Carrasco/Ena Menezes~~
Typist:	~~Debra Campbell~~Andrea Carrasco/Ena Menezes
Creation Date:	3/20/03
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Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date:	~~7/24/03~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Contract Requirements (HIPAA)

Any contract entered into between Tulare Local Health Care District and a third party must adhere to the following process:

1. The CEO and CFO must review all contracts. When appropriate, any contract shall be reviewed by legal counsel.

2. The contract language will include compliance with all JCAHO/DNV requirements and HIPAA regulations.

A. Business Associates (HIPAA)

All business associates of the hospital must have a signed business associate contract. The hospital staff may disclose protected health information to persons that meet the HIPAA regulation's definition of a business associate, or hire such persons to obtain or create protected health information for the hospital, only if hospital management obtains specified satisfactory assurances from the business associate that it will appropriately handle the information.

Hospital Administration Office will provide management with a standard contract specifying the required elements of the regulation to which a hospital business associate must agree to comply in order to properly safeguard protected health information.

The hospital's business associate contract must authorize the hospital to terminate the contract, if the hospital staff determines that the business associate has violated a material term of the contract.

Language that must be included in all contracts: Business Associates must implement administrative, physical technical safeguards to protect electronic confidential information and must require subcontractors to implement reasonable and appropriate safeguards to protect electronic confidential information.

If the business associate is required by law to act as a business associate to the hospital, the hospital staff may disclose protected health information to the business associate to the extent necessary to comply with the legal mandate without meeting the requirement to have a business associate contract if it makes a good faith attempt to obtain satisfactory assurances and if unable to do so, documents the attempt and the reasons that such assurances cannot be obtained.

This policy does not interfere with the relationship between the hospital and a business associate, or require the business associate to subordinate its professional judgment to that of the hospital.

The hospital staff may rely on the professional judgment of their business associates as to the type and amount of protected health information that is necessary to carry out a permitted activity.

B. Violations by Business Associates

When the hospital staff determines that there may be a violation of the hospital's contract by a hospital business associate, the Privacy Officer will be notified immediately.

The Privacy Officer will investigate all complaints or other information that may contain substantial and credible evidence of violations by a business associate, and act upon any knowledge of such violation that they possess.

The Privacy Officer will take reasonable steps to cure a breach or terminate the contract for business associate behaviors if they have knowledge of a material violation by a business associate.

If the staff has substantial and credible evidence of a violation, it is viewed as knowing of such violation.

Hospital management must terminate the contract when feasible if steps to cure such a material breach fail.

The Privacy Officer will notify the Secretary if it is determined that it is not feasible for the hospital to terminate the relationship with a non-compliant business associate.

3. The venue of the contract will be Tulare County and the applicable law must be California law where possible.

4. The payment terms must be reviewed for reasonableness and Tulare Local Health Care District is not subject to interest or late charges per section 818 of the Civil Code.

5. All independent contract agreements entered into must be generated from Administration.

6. All original contracts will be maintained in Administration. The department manager is responsible for maintaining a copy to ensure both parties comply with the terms of the contract.

7. All contracts will be logged by Administration. This log will be considered the hospital's main contract log.

8. The Board of Directors will approve all contracts.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Contract Requirements
Descriptive Type:	New Policy
Document Number:	11-1014
Attachments:	None
Author:	Rich Elkin ~~Rick Elkin~~~~Andrea Carrasco/Ena Menezes~~
Typist:	Andrea Carrasco/Ena Menezes ~~Julie Gresham~~
Creation Date:	7/06/06
Revision Date:	02/08/18
Prev. Dist. Date:	4/28/03

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date:	~~01/04/07~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	
HIPAA Compliance:	164.502(e) 164.504(e) 164.506(e)

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Contract Management

I. POLICY:

A. It is the policy of Tulare Local Health Care District dba Tulare Regional Medical Center (TRMC) to outline the responsibilities of the parties involved in contract management, including the procedures to be followed in the preparation, review, execution and monitoring of contracts.

B. It is the policy of the hospital, that any contract, regardless of name, involving a legally binding commitment between this hospital and another party, shall be prepared, reviewed, executed and monitored in a consistent manner to ensure legal and financial viability.

C. All contracts as outlined in this policy require annual management reviews of selected quality indicators to ensure that all contracted services, including all joint ventures, shared services and non-contracted services entities/individuals based on their ability to supply products and/or services that are safe and effective and that comply with all applicable Accreditation, CMS and/or CDPH standards and regulations and in accordance with the hospital's requirements. .

D. Contracts include, but are not limited to, Vendors, Independent Contractors, Memorandum of Understandings and Transfer Agreements.

E. Exceptions to this policy, includes vendors contracted through MedAssets or other departments that purchase supplies, products or maintenance service contracts through a Group Purchasing Organization (GPO).

II. PROCEDURE:

A. Responsibility for contract negotiation, retention and management depends upon the type of contract proposed.

B. The individual preparing a contract should secure a contract from the intended contracting agent or agency. When at all possible, two (2) original

contracts should be signed by the contracting party prior to submission to Administration for final signature by the CEO or CFO.

C. All new contracts that require payment by TRMC, shall require a W-9 to be completed by the vendor, contractor or subcontractor and submitted with the contract for final review and signatures.

D. In cases that involve sharing of Patient Healthcare Information (PHI), the contracting agency must also sign a Business Associates Agreement.

E. Contracts that require proof of general liability or auto insurance coverage by the contractor must be submitted with the contract.

F. Prior to submission, the Director must also complete a Contract Approval Term Sheet (CATS) and memo from the responsible party giving a brief explanation of the purpose for the contract and their recommendations.

G. Contracts shall then be forwarded to the Compliance Officer for review. At a minimum, the Compliance Officer will:

1. Note any required notification of liability carrier or need for additional coverage.

2. Ensure liabilities of both parties are clear and agreeable to the hospital.

3. Ensure the benefits of this service are essential, consistent with organizational mission and/or the benefits outweigh the risk.

4. Ensure staffing, licensing, training and patient safety issues have been adequately addressed.

5. Ensure unexpected consequences have been considered and mitigated when feasible.

6. Ensure this contract does not duplicate or conflict with other organizational contractual commitments.

7. Ensure notification clauses for unintended harm or complaints are clear and consistent with organizational capabilities and values.

8. Ensure the contract is consistent with the organization’s compliance program.

9. Verify that the contractor and/or contracting agency has not been excluded, debarred, suspended or otherwise been ineligible to

participate in Federal Health Care Programs, and procurement, or non-procurement programs.

H. If there are significant unresolved questions or risks the department director/ senior leader will be notified.

I. Once it is determined the contract meets all requirements as identified in this policy, the Compliance Officer will sign approval on the CATS form and forward to Administration for final approval.

J. All contracts must be signed by either the CEO or CFO to be effective and under certain circumstances may require board approval.

K. Once the contract has been signed and executed by either the CEO or CFO, the contract packet will be returned to the Compliance Officer and/or his/her designee.

L. The Compliance Officer or his/her designee shall forward a signed copy to the vendor or contracted agency for their records and to the finance department. The contract documents shall be maintained the in contract management database and the original contract and associated documents filed.

III. FORMS:

Requirement forms, i.e., W-9, Business Associates Agreement, CATS form and template contracts are available on the organizations shared drive.

Questions concerning any aspect of this policy/guideline should be referred to Administration or the Compliance Officer.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Contract Management

Descriptive Type: Revised Policy

Document Number: 11-1015

Attachments: None

Author: Julie Gresham

Typist: Andrea Carrasco/Ena Menezes

Creation Date: 08/17/12

Revision Date: 02/08/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Business Services and Admissions, Nursing Services, Emergency Services

FROM: Administration

SUBJECT: Admitting/Registration Policy

The purpose of the Admitting/Registration policy is to assure that all patients are treated equally.

1. "Admission" is defined as the admission of an individual to an in-patient care unit other than the Emergency Services Department or an observation unit.
   "Registration" is defined as the registration of an individual for outpatient ancillary or surgical services.

2. For a patient to be admitted a Staff Physician must order the admission of a patient in need of medical care.

3. Tulare Local Health Care District provides the following types of admission:

   a. Direct Admit

   b. O.B. Admit

   c. Emergency Admit

   d. Scheduled Surgery Admit

   and the following types of Registration:

   a. Outpatient Surgery

   b. All outpatient services.

4. All necessary admission and / or registration information (demographic and financial) will be obtained prior to or at the time of admission or as soon thereafter as possible.

5. No individual will be refused admission to Tulare Local Health Care District because of national origin, race, color, creed or religious belief.

6. No individual in need of immediate or urgent care will be refused admission to Tulare Local Health Care District because of inability to pay for services.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Descriptive Name: Admitting Policy

Descriptive Type: Revised

Document Number: 11-2001

Attachments: None

Author: Nancy Korvalis

Typist: Debra Campbell

Creation Date: 2/9/00

Revision Date: 03/5/18 Andrea Carrasco/Ena Menezes

Prev. Dist. Date: 1/17/00

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors:	~~5/22/02~~	

Effective Date: ~~5/23/02~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Documentation of the Medical Records Face Sheet by Admitting

I. Policy

It is the policy of Tulare Regional Medical Center to comply with Title 22 and other accreditation agency recommendations; and to provide timely information necessary for statistical and billing purposes.

II. Procedure

A. The following information shall be completed on all patients at the time of admission or registration:

- Complete legal name
- Address on admission
- Mailing address if different from residence
- Medical record number – assigned by HMS
- Billing number – assigned by HMS
- Social Security, Medicare and/or Medi-Cal numbers if applicable
- Date of birth
- Age
- Sex
- Marital status
- Religious Preference
- Primary Language Spoken
- Date and time of admission (assigned by HMS)
- Name, address and telephone number of person or agency responsible for the patient
- Name of insurance and/or third party payor
- Name of patient's attending and admitting physician
- Initials of admissions registrar – assigned by HMS
- Race of patient
- Room number or unit where patient was admitted

- Date of last admission and name used on previous admission and date of discharge

Admitting diagnoses on the face sheet must use approved abbreviations or symbols. (Refer to Policy #13-9028)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Documentation on the Medical Records Face Sheet by Admitting

Descriptive Type: Revised

Document Number: 11-2001.1

Attachments: None

Author: Nancy Korovillas/LuAnn Perry

Typist: Julie Gresham

Creation Date: 09/09/09

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

Prev. Dist. Date: 04/29/04

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

To: Admissions, Business Office

FROM: Administration

SUBJECT: Payment Arrangement Policy

Self-Pay Patient Payment Schedule

1. Monthly payments should be determined based on income, bank account balance, other daily living expenses and ability to pay.

2. If patient is not able to make payments, the Financial Counselor will assist the patient in arranging for financial assistance through other programs government or state.

3. Outstanding balances with or without monthly payment arrangements from previous admissions/visits may be combined in to one account for payment arrangements. Accounts with a balance prior to 12/12/2014 will not be eligible to be combined.

4. On elective procedures, payment arrangements will not be made if patient/guarantor has bad debt outstanding or open unpaid accounts. Elective procedures will be deferred until satisfactory arrangements have been made.

5. The Patient Access Staff will offer patients an installment payment plan without interest after all other options to secure full payment of an account balance (or estimated balance) have been considered and pursued.
6. Patients are expected to make the first installment at the time the payment plan is established. All subsequent payments will be made on a monthly basis.
7. Patients not fulfilling their financial arrangement will be required to make full payment for the balance due. The patient/guarantor will be issued a letter stating that, if payment in full is not received within ten (10) days, the account may be referred to an outside agency for collection.
8. The maximum time available to patients for completing their installment payment arrangements must not extend beyond thirty-six (36) months. Exceptions will be approved on the basis of financial hardship only.
9. Accounts with established installment payment plans will be monitored every 30 days to ensure payment arrangements have been met.
10. If the patient/guarantor is more than fifteen (15) days behind on a payment, or has missed a payment, the Patient Account Supervisor (PAS) will receive a report, which

identifies all delinquent patient accounts. The PAS reviews and approves the account for transfer to bad debt. The patient's account is updated and transferred to bad debt. (See Bad Debt Policy)

11. If a payment plan is established, the following guidelines should be followed:

PAYMENT SCHEDULE		
BALANCE DUE	**MIN. PAYMENT AMOUNT**	**MAXIMUM NUMBER OF MONTHS**
$0.00 - $35.00	$35.00	0
$36.00 - $250.00	$25.00	10
$251.00 - $500.00	$50.00	10
$501.00 - $1,000.00	$56.00	18
$1,001.00 - $2,000.00	$84.00	24
$2,001.00 - $3,000.00	$125.00	24
$3,001.00 - $5,000.00	$209.00	24
$5,001.00 - $10,000.00	$278.00	36
> $10,000	Discuss arrangements with Management	

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Payment Arrangement Policy
Descriptive Type:	Revised
Document Number:	11-2009
Attachments:	None
Author:	Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	02/26/00
Revision Date:	01/19/15
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	03/04/03

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Admitting

FROM: Administration

SUBJECT: Share of Cost

As part of Tulare Local Health Care District's (aka TDHS) effort to be cost effective and efficient, the documentation for patients with a share of cost will be recorded on the patient's account – AR notes.

TDHS's policy is to record on the AR notes for all applicable patients their share of cost. Even if the patient has a zero share of cost, it must still be so indicated on the AR notes.

On Medi-Cal accounts the Share of Cost will be assumed and billing must be completed immediately and will not be discounted. The Medi-Cal Share of Cost remains the patient's responsibility and is identified under financial class "51".

On Medicare the Share of Cost may be the patient's yearly deductible or a non-covered service. The Medicare Share of Cost or deductible will not be discounted. The Medicare, Share of Cost remains the patient's responsibility and is identified under financial class "41".

On commercial and Indemnity accounts the patient's Share of Cost may be their co-pay or deductible and will not be discounted. The balances after insurance payments are identified under financial class "I".

Patients with a Share of Cost are allowed to arrange a payment plan.

The goal of admitting staff is to identify such Share of Cost amounts and collect or set up payment arrangement prior to when service is rendered. Another effort of Share of Cost collecting must be made prior to discharge. If collection is not made at admission, another effort should be made by admitting staff to collect the share of cost prior to the patient being discharged. This effort should improve the timely collections and reduce the cost of billing and collecting. This policy is to support TDHS's efforts to operate under a paperless environment.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~9/26/02~~

APPROVED:

Board of Directors: ~~9/25/02~~

(11) Fiscal & Business
Admitting and Discharge:
Share of Cost
11-2018

Descriptive Name: Share of Cost

Descriptive Type: New

Document Number: 11-2018

Attachments: None

Author: Lucy Reimche/ Leon Dalva

Typist: Gillian Keith

Creation Date: 6-8-99 (originally by Lucy 5-11-99)

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	0925/02	

~~Revision Notes: To Leon Dalva per Lucy's instruction. General Board 9/25/02~~

Effective Date: ~~9/26/02~~

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Advanced Beneficiary Notice

I. Purpose:

This policy is intended to assist the Tulare Regional Medical Center and its entities in their efforts to comply with Medicare requirements associated with the use of Advance Beneficiary Notices (ABN) by providing uniform guidelines on when to use these forms and how they are to be completed

II. General Conditions:

Medicare will only pay for tests or services that meet the CMS definition of medical necessity. In order to preserve its right to bill the patient for non-covered services, Medicare requires that the provider inform the Medicare patient that the test or service ordered by his or her physician is not expected to be covered. Such notice must be in writing and is referred to as an Advance Beneficiary Notice (ABN).For patients who will receive the procedure despite Medicare decision to pay, the ABN process must be completed prior to providing the test or service. Tulare Regional Medical Center has implemented Experian Health Passport OrderChecker for tests and procedures not to be billed to Medicare or the patient in the event that the test or procedure will not be covered. The fundamental purpose of the ABN is to allow Medicare beneficiaries the option of accepting financial responsibility for services in the event that Medicare does not cover them, or decline receiving the services altogether.

It is the policy of Tulare Regional Medical Center to issue ABN's to Medicare beneficiaries in those instances where it is anticipated that the Medicare program will not cover the test or service that has been ordered. Medicare Advantage plans and prescription drug programs are not subject to an ABN.

The guidelines listed below must be followed in accordance with Medicare requirements:

a) An ABN must be in writing (see Exhibit A)

b) A complete ABN must be obtained before the test or service is performed. It is not necessary for the patient to sign the ABN in all instances; however, in those cases where it is not, a witness must sign.

c) The ABN must include the following:
1) A description of the test or service which may be denied.
2) Reason why the test/service may be denied.
3) Estimated cost for test or service.
4) Patient's name, Medicare number, date of birth, and treating physician
5) Patient or patient representative's signature and date or a witness signature and date.
6) Three Options regarding the item or service that may be non-covered:
- Option 1 – notice that the patient may both obtain the test(s)/service and agree to accept the responsibility for payment. Patient Appeal rights are retained for tests that are billed to Medicare for an official decision.
- Option 2 – notice that the patient may agree to obtain the test(s)/service and agree to accept financial responsibility however; does not want Medicare billed. Patient Appeal rights are forfeited under this option
- Option 3 – the patient may refuse test(s)/service and will not be financially responsible.

7) If non-covered services are repetitive or continuous, a single ABN may be issued. The duration of services must be described and may not exceed 1 year.

III. Procedure:

To help maximize compliance with Medicare requirements, an ABN must be obtained when non-covered tests or services ordered meets one or more of the following criteria:
- The test is for routine testing or screening purposes
- The test is for investigative or research purposes
- The diagnosis does not meet the medical necessity requirements
- There was no diagnosis provided by the physician
- There is a frequency limit for the test and performing the test would exceed that limit and therefore not be reimbursed.

1. The diagnosis on the order form must be reviewed by the Patient Access Staff when processing the outpatient Medicare order.
2. Patient Access Staff must determine whether or not the CPT code for the test/service that has been ordered is covered for the assigned diagnosis based on Medicare's medical review policies via lookup in the Health Information System. If the test/service is determined not to meet medical necessity, the responsible staff must produce an ABN from the Health Information System.
    a. If the Health Information System indicates that the diagnosis and services are not medically necessary and indicate the need for an ABN, Patient Access Staff may contact the ordering physician to inquire if there are additional diagnoses that may be more specific and medically necessary.

2. Explain the purpose of the ABN to the patient and request that he or she sign either an (1) agreement to pay for the test, bill Medicare for official decision on payment (2) agreement to pay for the test but do not want Medicare billed, or (3) deny responsibility and not obtain the test.
3. For patients that select Option 1 – Collection of the estimated cost or services should be obtained from the patient.
4. For patients that select Option 2 – Collection of the estimated cost or services should be obtained from the patient. Medicare should be deleted from the account to ensure Medicare is not billed. The account should be made self-pay. Patients need to be advised that secondary insurances will not process or pay claims without Medicare explanation of benefits. If patient has no other insurance, the account should be made self-pay.
5. For patients that select Option 3 – If no other test(s)/service(s) are performed and no charges are generated the account should be cancelled.
6. If the patient demands the test(s) and refused to sign the ABN form, the "refusal to sign" section of the ABN must be signed and dated by an employee as a witness.
7. The signed ABN form must be scanned into the Electronic Document Management (EDM) module of the Health Information System by Patient Access Staff. A copy should also be given to the patient.
8. Patient Access Staff administering the ABN should complete the medical necessity screens in the Health Information System.
9. In the event a patient refuses to sign the ABN and decides to have the procedure, the patient may be billed for the services.

IV. Quality Review:

1. A sampling of accounts that required an ABN will be reviewed for compliance.
2. An appropriate number of claims will be sampled based upon results and findings.
3. Results of the sampling and any recommendation should be shared with the Revenue Cycle Director and/or the facility CFO.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

EXHIBIT A:

A. Notifier:

B. Patient Name: C. Identification Number:

A. Advance Beneficiary Notice of Noncoverage (ABN)

B. NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider has good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare bi an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medica doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Me does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ OPTION 2. I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now a responsible for payment. I cannot appeal if Medicare is not billed.
☐ OPTION 3. I don't want the D. _____ listed above. I understand with this choice I am not responsible f payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-

Descriptive Name: Advanced Beneficiary Notice

Descriptive Type: New Policy

Document Number: 11-2019

Attachments: 1

Author: Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)

Typist: Melissa Arend

Creation Date: 01/19/15

Revision Date: None

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes-

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Medicare Secondary Payer (MSP)

SCOPE:

Applies to Patient Access Staff at all Registration area's

PURPOSE:

To comply with the Centers for Medicare and Medicaid Services (CMS) federal regulatory guidelines for Medicare Secondary Payer (MSP) section 1862(b) of the Social Security Act. These provisions prohibit Medicare from making payment if payment has been made or can reasonably be expected to be made by another payer.

POLICY:

A. In compliance with current Medicare regulations, a Medicare Secondary Payer (MSP) Questionnaire shall be completed for every Medicare patient for every visit.

B. All MSP Questionnaires must be retained on file (hard copy, scanned or electronic) for at least ten years in accordance with the Department of Justice's record retention requirements.

C. The following individuals shall be coded Medicare as secondary payer as outlined in the *CMS Medicare Secondary Payer Provider Manual*:

1. Who are aged 65 or older and currently working with coverage under an employer-sponsored or employee organization (such as a union) group health plan

2. Who are aged 65 or older and are covered by a working spouse's employer group health plan or employee organization (such as union) group health plan

3. Who are under age 65, disabled, and are covered by a large group health plan due to their own or other family member's current employment status

4. With kidney failure. Medicare is the secondary payer during the Coordination of Benefits (COB) period if they have coverage

5. Under their own, a spouse's, or other family member's employer-sponsored or employee-organization group health plan

6. Who received services covered under Worker's Compensation, Federal Black lung, automobile, no fault, or liability insurance plan

7. Who receive services covered under the Veteran Administration

PROCEDURE:

A. The Health Information System will be prompted by the patient's financial class to provide an electronic "Medicare Payer Questionnaire" form.

B. The Patient Access Staff complete a Medicare Payor Questionnaire at the point of pre-registration, registration, check-in or admission.

C. The questions outlined on the Medicare Secondary Payer Questionnaire must be asked of all Medicare patients. It is the responsibility of the Patient Access staff to assure that all questions be answered, as there may be situations where more than one insurer is primary to Medicare (e.g. Black Lung or Group Health Plan). The Patient Access staff will assure that all possible insurer(s) is/are identified.

D. It is the responsibility of the Patient Access staff to assure that all patients' encounter with a Medicare Financial Class will include a completed MSP Questionnaire form, in hard copy of electronic.

E. For the recurring patients, Patient Access Staff should initiate collection of MSP information from the first visit and obtain it once every 90 days during the span for patients receiving recurring outpatient services.

F. In the event a beneficiary cannot recall his or her or their spouses precise retirement date as it relates to coverage under a group health plan the Patient Access Staff shall follow the policies below as appropriate:

1. If the retirement occurred prior to his or her or spouses entitlement date, as shown on his or her Medicare card, hospitals report his or her entitlement as the retirement date.
2. If the beneficiary worked beyond his or her Medicare Part A entitlement date, had coverage under a group health plan during that time and cannot recall his or her or their spouses precise retirement date, but Patient Access Staff determines it has been at least five years since retirement, Patient Access Staff enters the retirement date as five (5) years retrospective of the date of admission.
3. If the beneficiary's or spouse's retirement occurred less than five (5) years ago, the Patient Access Staff shall obtain the retirement date from the appropriate informational sources; e.g. former employer or supplemental insurer.

G. Patient Access Staff will obtain information on possible Medicare Secondary Payor situations. Medicare patients or their representatives, at admission or start of care are asked if the services are for treatment of an injury or illness which resulted from an automobile accident or other accident, for which liability or no-fault insurance may pay, or for which another party is held responsible. This includes an incident that occurs on the provider's premises. The provider obtains the name, address and the policy number of any liability or no-fault insurance company or other party that may be responsible for payment of medical expenses that resulted from the accident or illness.

H. Patient Access Staff will inquire of the beneficiary or representative at the time of hospitalization is ordered, at admission, or when the service is rendered, whether the condition is work-related. When the patient or the patient's physician indicates that the condition is work-related or there are other indications that are work related. Patient Access Staff is required to ask the patient or the patient's physician, wherever possible, whether workers compensation is expected to pay.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Medicare Secondary Payer Policy
Descriptive Type:	New Policy
Document Number:	11-2020
Attachments:	None
Author:	Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	01/19/15
Revision Date:	None
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	**REFERENCE:** Medicare Part B Reference Manual CMS Medicare Secondary Payer Provider Manual http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf Chapter 3 – MSP Provider, Physician and Other Supplier Billing Requirements

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Charge Description Master Compliance and Maintenance

I. Policy:

1. It is the policy of TLHD to ensure the Charge Description Master (CDM's) is current, complies with federal, state and local regulatory agencies and efficiently support the needs of the organization including Revenue Service Departments, Revenue Cycle, HIM, Finance, Compliance, and Case Management.

II. Purpose:

1. The purpose of this policy is to define the methodology by which TLHD staff ensures the Facility CDM is current and in compliance with reimbursement guidelines provided by the Centers for Medicare and Medicaid Services (CMS), Medi-Cal, Workers Compensation and all other third party payors.

III. Definitions:

1. Charge Description Master (CDM): The CDM is a data base of chargeable items, services and supplies used in patient care. Each line item consists of a department identifier, a charge item number, a billing description, a CPT or HCPCS code when applicable, a Revenue Code, and a Relative Value Unit (RVU) when applicable, and patient charge amount per item.

2. The CDM master file contains the following fields: 25 character billing description; Medicare CPT/HPCPCS code; Medicare outpatient UB92 Revenue code; TLHD assigned Relative Value Unit (RVU) when applicable; Medi-Cal local codes; TLHD CDM is accessible on the TLHD Intranet. The CDM is a dynamic document, updated as regulatory changes are received. The TLHD Hospital Charge Description Master resides in the patient accounting system. The charge master contains billing elements as well as fields for all payers, pricing and extended description fields. The CDM files are maintained by the TLHD Patient Accounting Director or CDM Liaisons/Analyst.

IV. Principally Affected Departments:

1. TLHD Facility Inpatient and Outpatient departments; CDM Analysts/resources; Patient Financial Services (PFS) Health Information Management (HIM); Finance; Managed Care, Care Management, Corporate Compliance, TLHD IT, and TLHD enterprise resources supporting revenue cycle applications.

V. Guidelines:

1. Facility Charge Description Master:

A. It is the responsibility of the Chief Financial Officer (CFO) to ensure that the Facility has designated, trained personnel assigned primary responsibility for maintaining the Facility CDM in accordance with federal and state regulations, the Corporate Standard and TLHD policies.

B. The facility is to:

1. Establish Facility-based pricing policies for procedures, supplies, pharmaceutical items, laboratory and other services.

2. Ensure that each clinical department receives training regarding CDM maintenance and the relationship between order entry, encounter forms, documentation, changes in procedures/services/supplies and the CDM.

3. Keep abreast of regulatory changes and respond in a timely manner to all CMS transmittal action plans distributed by TLHD Compliance Subject Matter Leads.

4. Ensure that department order entry systems and processes are linked accurately to the CDM and updates are made in a timely matter. This includes electronic and paper processes i.e. charge tickets (encounter forms), charge/order entry screens and automated interfaces.

5. Ensure that all CDM changes are communicated to the effected departments and application leads, and corrective action is taken to maintain system synchronization.

6. Establish internal communication processes between the CDM Liaison, Patient Financial services, HIM, TLHD Information Technology and Managed Care Contracting to ensure CDM data flows accurately to the patient bill.

7. Establish department specific charging processes to include charge reconciliation. At a minimum each department should perform at least 3 times a week charge reconciliation between all touch points in the charging process. This includes: reconciliation of volumes between order entry and patient accounting in addition to spot audits of charge tickets and/or order entry to the patient account in the billing systems.

8. Submit CDM data to the appropriate state agencies in accordance to State and Federal Charge Master reporting laws as well as TLHD policy.

9. Obtain approval from the CDM Liaison to track statistical information through the Facility CDM for non-Standard items.

C. The TLHD CDM:

1. The Patient Accounting Department is responsible for creation and maintenance of the TLHD CDM, communicating changes and alignment monitoring. The CDM is maintained continually to ensure compliance with Centers for Medicare and Medicaid Services (CMS), Medical and Workers Compensation.

2. The following items are reviewed for alignment to the CDM:

   a. 25 Character Billing Descriptions
   b. Medicare Outpatient UB92 Revenue Code
   c. Medicare CPT/HCPCS
   d. Medicare Modifiers
   e. Medi-Cal Codes
   f. Medi-Cal Modifiers
   g. RVU's and statistical charges
   h. Patient charge

3. The CDM Analyst/Liaison is responsible for determining the needed action to correct the discrepancy, which requires that the following actions be taken:
   a. Immediately correct discrepancies where CPT/HCPCS codes or UB92 Revenue Codes are identified as incorrect. All other discrepancies must be corrected within 10 working days.
   b. Ensure file maintenance is completed prior to the next scheduled download.
   c. Alert, as needed, applicable departments of any suspected data integrity sues or issues with download timing that have resulted in invalid discrepancies.
   d. Request an exception if state or local regulations require a deviation from agreed practice.

2. Procedure to Request an Addition or Change to the Standard

A. TLHD requesting department should first check available resources to determine if the item is valid and patient chargeable.

1. If the item is valid: TLHD follows CDM maintenance policy to add item to the CDM. It is TLHD Patient Accounting Department's responsibility to populate the code field in the CDM with the appropriate series of established codes.

2. If the item is not present, the requestor completes CDM Add Request form: All fields in the CDM Add Request Form must be completed upon submission to the PFS. The PFS may request additional information or clarification as needed. All forms must be approved by respective Department Director.

3. CDM Add/Change Request will be returned to the CDM Liaison as approved or denied. Every attempt will be made to process Add/Change requests within 72 hours for Procedures and 48 hours for Pharmaceuticals and supplies. All requests will be returned to the requestor within 5 days of submission.

4. Approved requests will be added to the CDM.

5. Denied requests will be sent back to the requestor with the reason for denial stated on the form.

6. CDM changes will be made in the CDM.

3. The TLHD Patient Accounting Department generates routine update bulletins containing all changes that have occurred in the CDM since the prior update.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Charge Description Master Compliance and Maintenance

Descriptive Type: Revised

Document Number: 11-3004

Attachments: None

Author: Erin Fanning

Typist: Julie Gresham

Creation Date: 11/12/08

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

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Board of Directors	~~11/19/08~~	

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Forward To: Policy Binders (PBX and Administration) and Post tp Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Charge Master & AB 1045 Reporting Requirements and Payer's Bill of Rights – AB 1627

I. Purpose

On July 28, 2004 with policy 11-3004, Hospital charges (Charge Description Master – CDM) was established to comply with AB 1627 and has made the Charge Description Master (CDM) available to the public in accordance with California Health and Safety Code and provided a copy of the CDM and a list of charges for 25 commonly charged services or procedures to OSHPD on July 1, 2005 as required by law.

AB 1045 has changed the reporting requirements under AB 1627 and therefore this policy is adopted along with revisions to policy 11-3004 to comply with AB 1045.

II. AB 1045 REPORTING REQUIREMENTS:

Tulare Local Health Care District will comply with the following AB 1045 Reporting Requirements listed below:

A. AB 1045 requires that each hospital submit a list of charges for 25 common outpatient procedures ***instead of*** the list of 25 commonly charged services or procedures.

1. **List of Charges for 25 Common Outpatient Procedures:**
   a. AB 1045 does not define "procedures", but it is expected that hospital will submit charges for a combination of ambulatory surgical procedures, ancillary therapeutic procedures, and ancillary diagnostic test and procedures.
   b. Charges related to medical supplies, durable medical equipment, and pharmaceuticals should not be reported.
   c. The reported procedures do not have to be the 25 most commonly charged outpatient procedures, just 25 common outpatient procedures.

2. Hospital to provide upon request a written estimate of the amount the hospital will require an uninsured person to pay for hospital services that are reasonably expected to be provided, based on average length of stay and services provided for the person's diagnosis. Estimates are not required for emergency services.

    a. Tulare Local Health Care District's policy has been that, the requesting party will meet with either the Director of Patient Accounting or Director of Admitting on scheduled time to go over the request

3. Hospital to provide information about the hospital's financial assistance and charity care policies to uninsured patients, along with contact information for a hospital representative, to obtain more information about these policies.

    a. Tulare Local Health Care District has previously established policy and procedures on uninsured person(s). These policies are listed on the hospital's Intranet.
    b. Uninsured person(s) are offered 30% cash discounts per policy 11-2012.
    c. Uninsured person(s) who is not able to pay for services are assisted with Hospital Financial Counseling Services per policy 11-5000. Financial Counselors determine the appropriate financial sponsor via County, State or Federal programs.
    d. Uninsured person(s) who are not eligible for any County, State or Federal programs are evaluated for Charity Care Program under Hospital policy 11-1002.

4. Hospital to provide a copy of an inpatient DRG list and the outpatient procedure list to any person upon request. As suggested by OSHPD, the hospital will download the Statewide Benchmark Top 25 Inpatient DRG list from OSHPD's web site at:

    http://www.oshpd.ca.gov/HQAD/PatientLevel/index2.htm

    a. A copy of this document will be kept electronically and be made available to individuals upon request.

5. Under the supervision or control of the Director of Patient Accounting or Director of Admitting, the Hospital will have a hard or electronic copy of its charge master and make it available to individuals who require it. Per policy 11-3004, the Director of Patient Accounting, the Admitting Director and Administration

(CEO/CFO) are the only personnel authorized to make this list available.

III. PROCEDURES TO OBTAIN BILL OF RIGHTS INFORMATION:

A. Any request for Bill of Rights information listed under AB 1627 or AB 1045 shall be directed to either the Direct of Patient Accounting or Director of Admitting or Administration.

B. The requesting party will meet with either the Director of Patient Accounting or Director of Admitting during a scheduled appointment.

C. Signage will be placed in Admitting, Emergency Department and Billing Offices areas, notifying the public that the CDM is available for review and the procedure to request said information.

D. The Director of Patient Accounting, the Admitting Director or Administration (CEO/CFO) is the only individuals authorized to explain the charge master.

E. Authorized personnel will review the Individual Disclaimer Notice with any person(s) requesting to review the CDM, and request a signature on the Individual Disclaimer notice. Signed disclaimers will be maintained in Administration.

F. Any information about charges provided pursuant to this policy shall include information about where to obtain information regarding hospital quality, including hospital outcome studies available from OSHPD and hospital survey information available from the Joint Commission for Accreditation of Healthcare Organizations.

Draft Disclaimer:

This Charge Description Master (CDM) is made available for your inspection based on Chapter 2 of Division 2, commencing with Section 1339.50 of the California Health and Safety Code.

The charges contained in this document are the same for all patients of this facility regardless of insurance program or coverage. However, the charges contained in this document do not reflect expected reimbursement, since health plans negotiate reimbursement rates based on a number of factors. Other issues affecting actual reimbursement could include whether a procedure was done on an inpatient or outpatient basis, physician orders, co-morbidities and complications, medical necessity, services and procedures provided at this facility, the community served and many others.

Charges referenced in this document were valid on date electronic file was executed. These charges may have changed since this date due to new technology, added or eliminated services, goods and/or procedures, changes made by manufacturers and vendors, etc., and may be subject to change due to increases from venders for such items as implants, prosthetics, etc.

The physician orders, based on his/her examination and treatment of the patient, are the key components to which services and procedures are charged to an individual patient. There are many components that comprise one hospital bill. For example, one short hospital inpatient stay could include surgical procedures, treatment in the emergency department, supplies, pharmaceuticals, numerous tests (i.e., x-rays, laboratory), room and board, respiratory and physical therapy and so forth (all based on a physician's orders). Therefore, this document should not be used to accurately estimate the final patient cost of a given hospital stay. It is provided for information only. Descriptions and charges contained in this document will vary from facility to facility.

Additionally, this hospital provides discounted care to low-income uninsured patients. Please contact our financial counselor at (559) 685-3434 for more information on programs and eligibility.

The information contained in this CDM is provided in compliance with the above statute and is specific to this facility.

I have read and understand the above disclaimer.

Name _____ Date _____

Signature_____

Tulare Local Healthcare District
AB 1627
Administration (559) 685 3462

In compliance with California Health and Safety Code Section 1339.50, this facility's Charge Description Master (CDM) is available for public inspection.

To review these items, contact Administration at (559) 685-3462 and an appointment will be scheduled.

The Charge Description Master will be made available in accordance with the hospital policy. Any individual requesting to review the CDM will be asked to sign an Individual Disclaimer Notice.

For patients requiring financial counseling services, please contact the hospital's Financial Counseling Department at (599) 685-3434

E:\Policies ready for board approval\11-3004.1 Charge Master and AB1045 Reporting Requirments and Payor's Bill of Rights AB1062.doc Effective Date: June 29, 2006

Descriptive Name:	Charge Master & AB 1045 Reporting Requirements and Payer's Bill of Rights – AB 1062
Descriptive Type:	Revised
Document Number:	11-3004.1
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Author:	Lucy Reimche
Typist:	Julie Gresham
Creation Date:	6/1/06
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Board of Directors	~~06/28/06~~	

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Forward To: Policy Binders (PBX and Administration) and Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Admitting, Patient Accounting and Finance

FROM: Administration

SUBJECT: Bad Debt Accounts

I. Defining Bad Debt

A. A bad debt is defined as a debt that the debtor has the ability to pay but will not pay after 150 days of hospital collections activity. It excludes charity debt. The purpose of this policy is to ensure that bad debt accounts are handled consistently and appropriately.

B. An account is generally considered a bad debt when it meets one or more of the following criteria:

1. The guarantor does not or will not fulfill customary terms of payment, including financing.

2. The guarantor does not respond to established collection follow-up efforts.

3. The guarantor refuses to obtain public assistance that he/she may qualify for, or is denied public assistance for which they appear to qualify.

4. The guarantor has filed for bankruptcy.

II. TYPES OF BAD DEBT ACCOUNTS

A. Self-pay bad debt consists of account balances due from the guarantor, other than Medicare account balances.

B. Medicare bad debt consists of account balances remaining after Medicare has completed payment, and meeting a special definition as determined by CMS (Centers for Medicare & Medicaid Services).

III. RESOLUTION OF BAD DEBT ACCOUNTS

A. Self-pay bad debt accounts are placed with an outside collection agency. An exception is made for bankruptcy filings; the bad debt write-off is performed, but the account is not placed with an outside collection agency.

B. Medicare bad debts are also placed with an outside collection agency. The collection agency shall be instructed to perform collection follow-up in accordance with CMS guidelines for Medicare bad debts, and shall be able to provide appropriate evidence of compliance. Essentially, Medicare bad debts shall receive the same collection efforts as self-pay bad debts

C. Patient Financial Services (PFS) department will review the Health Information System's (HIS) bad debt pre-list report weekly to screen accounts that qualify for bad debt.

D. PFS manager will send an electronic copy of the bad debt report to the facility CFO for approval of write off, prior to sending to the collection agency.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Bad Debt Accounts

Descriptive Type: Revised

Document Number: 11-3022

Attachments: None

Author: Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)

Typist: Melissa Arend

Creation Date: 09/26/02

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Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Admitting, ACU

FROM: Administration

SUBJECT: Deposit Schedule

DEPOSIT SCHEDULE

All uninsured patients will be asked to prepay a portion of their hospital bill, as follows.

Type of Care	Deposit
OB-Normal Delivery	$2000
OB-C-Section	$5000
LAVH,ESWL,Lap Choley	$5000
Other Surgeries	$2000
OP Endoscopy	$1000
OP Medical Imaging Exams	50% of charges
ICU	$2000
Other Units	$1000
Emergency Room	$150

***Emergency room patients shall be asked only after completion of examination.

All requests will be evaluated with the patient's ability to pay pursuant to the hospital policy #11-1002 Charity Care Program.

Co-Pays, when known, will be collected at time of service or upon discharge, patients insurance should be verified prior to services rendered for nonurgent scheduled exams or admissions.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Descriptive Name: Deposit Schedule

Descriptive Type: Revised

Document Number: 11-3024

Attachments: None

Author: Nancy Korovilas / Lucy Reimche

Typist: Debra Campbell

Creation Date: 11/13/02

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Board of Directors	~~1/22/03~~	

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Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Clinical Guidelines, General Guidelines

FROM: Administration

SUBJECT: Contract Negotiations with Third Party Payors

POLICY:

Due to escalating costs and other market forces, TDHS will not enter or continue an agreement with a third party Payor which is below TDHS's total operational costs plus five (5) percent.

For existing contracts that do not meet this criterion we will review the agreement and send termination notices. The health plan will at that time have the opportunity to renegotiate the agreement with TDHS in good faith.

The negotiation, termination and execution of any agreement will be performed by staff with the oversight of appropriate experienced legal counsel when needed. This policy authorizes staff to engage the appropriate counsel to review and assist with necessary termination and collection on contracts.

Participating in the Medicare, Medi-Cal traditional and TCMS programs is excluded from this policy.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Descriptive Name: Contract Negotiations with Third Party Payors

Descriptive Type: New Policy

Document Number: 11-3026

Attachments:

Author: Lucy/Bob

Typist: Jody Ellis

Creation Date: 11/2/04

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Board of Directors	~~2/26/05~~	

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Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Point of Service Cash Collection

I. PURPOSE:

Tulare Regional Medical Center will request that co-payments, deductibles, co-insurance amounts specified by insurance plans, and self pay balances are collected prior to or at the time services are provided. Payment for non-emergent services requested by self-pay patients shall be collected in full prior to or at the time of service(s). Emergency care will be provided to individuals regardless of their ability to pay and will not be collected until a medical screening exam has been rendered by the appropriate clinical staff. Emergent, urgent, and emergent elective patients may also be eligible for hospital charity program and Self-Pay Discount Policy. This will ensure the financial viability of Tulare Regional Medical Center by minimizing the cost of collection efforts and the risk of non-payment by patients after discharge.

II. POLICY:

A. Tulare Regional Medical Center will require payment prior to or at the time of service for all non-emergent services. In situations where coverage is in question, uncertain, or contested, Tulare Regional Medical Center will require a minimum payment based on the payment matrix for the services rendered on or before the patient's admission/service, and the balance within thirty (30) days of final bill receipt.

B. For non-emergent services, if an individual does not meet their financial obligation including meeting the deposit as well as precertification requirements, the services may be rescheduled until the individual adheres to the Upfront Collections Policy and Procedure. This excludes patients who seek emergent care as defined by EMTALA.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Point of Service Cash Collection

Descriptive Type: ~~New~~ Revised Policy

Document Number: 11-3027

Attachments: None

Author: Karan Levering

Typist: Julie Gresham

Creation Date: 10/24/11

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TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

DELETE

SUBJECT: Financial Assistance (Charity Care) Program

PURPOSE:

To provide charity or partial-pay charity to patients who may not qualify for State, Federal, County or other assistance and have no reasonable means to pay.
The mission of Tulare Regional Medical Center California is to provide safe, efficient, technologically advanced healthcare with the respect for the diversity of our region.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Monetary assets and income may be considered when determining eligibility under this Charity Care Policy. Monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans. The first ten thousand dollars ($10,000.00) of a patient's monetary assets shall not be counted in determining eligibility, nor shall fifty percent (50%) of a patient's monetary assets over the first ten thousand dollars ($10,000.00) be counted in determining eligibility. Net worth shall be considered including eligible liquid and non-liquid assets owed less liabilities and claims against assets. (Reference AB774, Health & Safety Code § 127405)

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

Gross charges: The total charges at Tulare Regional Medical Center established rates for the provision of patient care services before deductions from revenue are applied.

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

POLICY:

Tulare Regional Medical Center (TRMC) is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. TRMC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. TRMC will provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility for financial assistance or for government assistance.

Accordingly, this written policy:

- Includes eligibility criteria for financial assistance – free and discounted (partial charity) care
- Describes the basis for calculating amounts charged to patients eligible for financial assistance under this policy
- Describes the method by which patients may apply for financial assistance
- Describes how the hospital will widely publicize the policy within the community served by the hospital
- Charity is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with TRMC's procedures for obtaining charity or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets.
- TRMC recognizes that there may be unusual or extenuating financial circumstances which may exceed the specific criteria as established in this policy and warrant special consideration. In such cases, a description of the unusual circumstances should be forwarded by Hospital staff to the Director of Revenue Cycle/ or designee for review and then forward to the Chief Financial Officer who will make the final determination as to the amount, if any, of financial assistance allowance to be granted.

In order to manage its resources responsibility and to allow TRMC to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of patient charity.

PROCEDURE:

A. Services Eligible Under This Policy. For purposes of this policy, "charity" or "financial assistance" refers to healthcare services provided by TRMC without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

1. Emergency medical services provided in an emergency room setting;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at TRMC's discretion.

B. **Eligibility for Charity**. Eligibility for charity will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this policy. The granting of charity shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

C**. Method by Which Patients May Apply for Charity Care.**

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may

a. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. Documentation may include, but is not limited to: most recent pay check stub(s), copies of bank statements, and the most recent tax filings.

b. Include the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);

c. Include reasonable efforts by TRMC to explore appropriate alternative sources of payment and coverage from public and private payment programs and to assist patients to apply for such programs (including, but not limited to, Medicare, Healthy

Families Program, Medi-Cal, coverage offered through the California Health Benefit Exchange, California Children's Services program, other state- or county-funded health coverage);

d. Take into account the patient's available assets and all other financial resources available to the patient; but shall not include statements on retirement or deferred-compensation plans qualified under the Internal Revenue Code, or non-qualified deferred-compensation plans.

e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

2. It is preferred but not required that a request for charity and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for charity becomes known.

3. TRMC's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of charity. Requests for charity shall be processed promptly and TRMC shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

D**. Presumptive Financial Assistance Eligibility**. There are instances when a patient may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with charity care assistance. In the event there is no evidence to support a patient's eligibility for charity care, TRMC could use outside agencies in determining estimate income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write-off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;

2. Homeless or received care from a homeless clinic;

3. Participation in Women, Infants and Children programs (WIC);

4. Food stamp eligibility;

5. Subsidized school lunch program eligibility;

6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

7. Low income/Subsidized housing is provided as a valid address; and

8. Patient is deceases with no known estate.

E. Tulare Regional Medical Center will comply with Office of Statewide Health Planning and Development (OSHPD) reporting requirements including the following information:

1. Submission of charity care and discount policies bi-annually
2. Submission of eligibility procedures for charity care and discount payment bi-annually
3. Submission of review procedures for charity care and discount payment bi-annually
4. Submission of the application used for charity care and discount payment bi-annually (These policies will be reported to the OSHPD using their online procedure)

F. **Eligibility Criteria and Amounts Charged to Patients**. Services eligible under this policy will be made available to the patient in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. Once a patient has been determined by TRMC to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

The basis for the amounts TRMC will charge patients qualifying for financial assistance is reflected on Exhibit 1 of this policy.

H. **Relationship to Collection Policies**. TRMC's management shall develop policies and procedures for internal and external collection practices (including actions the hospital may take in the event of non-payment, including collections action and reporting to credit agencies) that take into account the extent to which the patient qualifies for charity, a patient's good faith effort to apply for a governmental program or for charity from TRMC, and a patient's good faith effort to comply with his or her payment agreements with TRMC. For patients who qualify for charity and who are cooperating in good faith to resolve their discounted hospital bills, TRMC may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. TRMC will not impose extraordinary collections actions such as wage garnishments, liens on primary residences, or other legal actions for any patient without first making reasonable efforts to determine whether that patient is eligible for charity care under this financial assistance policy. Reasonable efforts shall include:

1. Validating that the patient owes the unpaid bills and that all sources of third-party payment have been identified and billed by the hospital;

2. Documentation that TRMC has or has attempted to offer the patient the opportunity to apply for charity care pursuant to this policy and that the patient has not complied with the hospital's application requirements;

3. Documentation that the patient does not qualify for financial assistance on a presumptive basis;

4. Documentation that the patient has been offered a payment plan but has not honored the terms of that plan.

I. **Regulatory Requirements**. In implementing this Policy, TRMC management and facilities shall comply with all other federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

A monthly charity care report summary, with supporting individual documentation, will be signed off by the Director of Revenue Cycle and Chief Financial Officer. Upon completion of signatures, the report will be forwarded to the Finance Department. Patient Financial Services will retain the summary report and supporting documentation for seven (7) years

Notice of the TRMC's policy for financially qualified and self-pay patients shall be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to, all of the following:

- Emergency Department
- Billing Office
- Admissions Office
- Other Outpatient settings

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Exhibit 1 (Example)

Federal Poverty Levels – 350%

Family Unit*	Poverty Guidelines*	
1 person	$ 40,845	2 persons
55,055		
3 persons	69,265	4 persons
83,475		
5 persons	97,685	
6 persons	118,950	

$14,210/per additional person

*Based on the 2014 Federal Poverty Level as published in the Federal Register in January 2014 and effective February 10, 2014**. The FPL can be updated every year.**

Descriptive Name: Financial Assistance (Charity Care) Program

Descriptive Type: Revised

Document Number: 11-3028

Attachments: None

Author: Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)

Typist: Melissa Arend

Creation Date: 04/15/12

Revision Date: 01/19/15

Prev. Dist. Date: 07/26/12

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	01/28/15	

Effective Date: 01/29/15

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments: **REFERENCES:**

CA AB774 (2005) Hospital Fair Pricing Policies
CA SB350 (2007-2008) amends Sections 127400, 127405, 127425, 127440, and 127444 of the Health and Safety Code, related to Hospitals (Hospitals: discount payment and charity care policies)
CA SB1276 (2013-2014) amends sections 127400, 127405, 127420, 127425, 127450, 127454, and 127455 of the Health and Safety Code, relating to health care billing
California Health & Safety Code § 127400 – 127446
The 2010 Patient Protection and Affordable Care Act (PPACA)

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Uninsured Discount Policy

PURPOSE
To establish a policy that insures uniform application of a discount for patients who do not have any type of health insurance and do not qualify for assistance under the financial assistance policy.

All patients who have no source of insurance and do not qualify for financial assistance will receive a 50 percent discount of total charges for services as long as the discount does not violate the policy of charging below Medicare/Medi-Cal rates.

If at a later time, the patient is found to have insurance, the discount will be reversed.

Additional Discount:
Additional discounts may be available on an individual basis upon approval of the Patient Access Director, Receivables Manager, Receivables Vice President, and/or Chief Financial Officer.

Procedure:
The 50% discount will be applied at the time of final bill.

In special circumstances, all reasonable offers will be considered to resolve the account with the following approval guidelines.

a. $0-$25,000- Patient Access Director/Manager Receivables
b. Over $25,001- Chief Financial Officer

Questions concerning any aspect of this policy/guideline should be referred to Patient Access or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~04/04/13~~ (11) Fiscal & Business
Patient Accounting:
Uninsured Discount Policy
APPROVED: 11-3029

Board Of Directors: ~~04/03/13~~

Descriptive Name: Uninsured Discount Policy

Descriptive Type: New Policy

Document Number: 11-3029

Attachments: None

Author: Karan Levering, Director, Patient Access (First Source) in conjunction with the Chief Financial Officer, TRMC

Typist: Karan Levering

Creation Date: 03/01/12

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~04/03/13~~	

Effective Date: ~~04/04/13~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Collection Policy

PURPOSE

To establish a policy that insures uniform collection activity for all self pay balances, including insured and uninsured consumers. A small balance adjustment will occur for all accounts under $25.00. There are three sections to this policy.

Discounts (Separate from Policy 11-3028 Financial Assistance (Charity Care) Program
Payment Plans
Bad Debt

I. Discounts

For Uninsured Patients:
Please refer to the Uninsured Policy for discount rates for patients that have no health insurance coverage.

For Insured Patients:
30 Day Discount
The Hospital will offer a 30% discount for any out of pocket expense paid within 30 days of service unless the discount is not permissible per the insurance contract.

Additional Discount:
Additional discounts may be available on an individual basis upon approval of the Patient Access Director, Receivables Manager, Receivables Vice President, and/or Chief Financial Officer (CFO).

II. Payment Plans
In order to assist patients in meeting their financial obligations to the hospital, Tulare Regional Medical Center will allow for payment plans within the following guidelines:

Minimum Payment: $50 per month
Maximum Time: 12 months

If the patient is unable to meet these requirements, special consideration may be made by the Manager, Receivables; Director, Patient Access; Vice President, Receivables; and/or Chief Financial Officer

III. Bad Debt

This insures accounts deemed uncollectible are uniformly placed with designated collection agency. Patients excluded from this policy are those that would qualify under the financial assistance policy.

PROCEDURE

I. Discounts

Upon request, the 30 day discount will apply once the insurance company has adjudicated the claim, if the patient pays in full within 30 days. In all cases, only one discount may be applied to an account. In special circumstances, all reasonable offers will be considered to resolve the account with the following approval guidelines.

a. $0-$25,000- Patient Access Director/Manager Receivables
b. Over $25,001 Chief Financial Officer

Payment Plans

When contacting a patient to resolve the account balance, the first attempt is to resolve the balance in full. 30-day discounts or additional discounts may apply.

If the patient is not able to pay the balance in full, a payment plan will be offered. If the patient expresses financial need, the patient will be screened for other assistance programs.

II. Bad Debt

Non-Medicare accounts that remain uncollected after sixty days with 2 attempts to notify patient by mail of the debt are subject to placement with bad debt agency. Patients that have requested financial assistance or are in the process of applying for, or have received financial assistance are exempt from the bad debt policy.

Medicare accounts that remain uncollected after a period of one hundred twenty days with four attempts to notify patient by mail of the debt are subject to placement with a collection agency.

Mail return accounts that remain uncollected are subject to immediate placement with a collection agency.

Minimum amount to be placed with bad debt: $25.00

All placements with a collection agency require the following approvals:

a. $0-$5,000 Patient Access Director
b. Over $5,000- Chief Financial Officer

Questions concerning any aspect of this policy/guideline should be referred to Patient Access or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Collection Policy
Descriptive Type:	~~New~~Revised ~~-~~Policy
Document Number:	11-3030
Attachments:	None
Author:	Karan Levering, Director Patient Access (First Source), in conjunction with the Chief Financial Officer, TRMC
Typist:	Karan Levering
Creation Date:	04/15/12
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~07/25/12~~	

Effective Date:	~~07/26/12~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Billing Medicare Outpatient 3-day Window

OBJECTIVE:

To establish guidelines for billing Medicare outpatient services provided prior to an inpatient admission in accordance with the Centers for Medicare and Medicaid Services (CMS) regulations.

POLICY:

Outpatient services provided by TRMC will be combined with the Medicare Part A admission under the following circumstances.

- **Hospitals paid under the Prospective Payment System (PPS) for acute care services:**
  - All outpatient diagnostic services provided within three days prior to the inpatient admission must be combined with the inpatient admission. Any services, items and/or supplies that are integral to the performance of a diagnostic procedure will also need to be combined with the inpatient admission.
  - All related therapeutic or related non-diagnostic services provided within three days prior to the inpatient admission must be combined with the inpatient admission if the diagnosis is related.

- **Hospitals or Distinct Part Units excluded from the PPS for acute care services:**
  - All outpatient diagnostic services provided within one day prior to the inpatient admission must be combined with the inpatient admission. Any services, items and/or supplies that are integral to the performance of a diagnostic procedure will also need to be combined with the inpatient admission.
  - All related therapeutic or related non-diagnostic services provided within one day prior to the inpatient admission must be combined with the inpatient admission.

The following exceptions apply to this policy:

- **Home Health Agency (HHA):** Services provided within the applicable "window" by an HHA wholly-owned or operated by HS do not need to be combined with the inpatient

admission unless such services are diagnostic and payable under Medicare Part B. Diagnostic services payable under Medicare Part B that are rendered by an HHA wholly-owned or operated TDHS must be combined with the inpatient admission.

- **Skilled Nursing Facility (SNF):** Services provided within the applicable "window" by a SNF wholly-owned or operated by TDHS do not need to be combined with the inpatient admission unless such services are diagnostic and payable under Medicare Part B. Diagnostic services payable under Medicare Part B that are rendered by a SNF wholly-owned or operated by the admitting facility must be combined with the inpatient admission.

- **Hospice:** Services provided within the applicable "window" by a Hospice wholly-owned or operated by the CMHS do not need to be combined with the inpatient admission unless such services are diagnostic and payable under Medicare Part B. Diagnostic services payable under Medicare Part B that are rendered by a Hospice wholly-owned or operated by the admitting facility must be combined with the inpatient admission.

- **Ambulance transportation services:** Ambulance transportation services provided within the applicable "window" by an entity wholly-owned or operated by TDHS do not need to be combined with the inpatient admission unless such services are rendered during an inpatient admission for the purpose of the patient receiving specialized services not available where the patient is an inpatient. When rendered during an inpatient admission, the cost of ambulance transportation services should be included in the ancillary cost center representing the specialized service provided.

- **Maintenance renal dialysis:** Maintenance renal dialysis provided within the applicable "window" by an entity wholly-owned or operated by TDHS does not need to be combined with the inpatient admission.

- **Physician professional services:** Professional services personally furnished by physicians do not need to be combined with the inpatient admission.
- **Screening Mammograms:** Screening mammograms are exempt from the applicable payment window and should not be combined with the inpatient claim.

Under no circumstances will outpatient services be provided in order to:

- **Avoid combining outpatient services with anticipated inpatient admissions at another facility.**

- **Avoid combining the outpatient services with inpatient admissions by purposefully scheduling services for such reason prior to the applicable "window" as outlined in this policy.**

DEFINITIONS:

Window: Three days (Midnights) prior to an inpatient admission for acute care PPS hospitals and one day prior to inpatient admission for hospitals or units (example: CFH Telephone Clinic –stand alone) exempt from acute care PPS.

Diagnostic Service: An examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury. For this provision, the following revenue and/or HCPCS codes are always considered diagnostic:

- 254 – Drugs incident to other diagnostic services;
- 255 - Drugs incident to radiology;
- 30X - Laboratory;
- 31X – Laboratory pathological;
- 32X – Radiology diagnostic;
- 341 - Nuclear medicine, diagnostic procedures;
- 343 - Nuclear medicine, diagnostic;
- 35X - CT scan;
- 371 - Anesthesia incident to radiology;
- 372 - Anesthesia incident to other diagnostic services;
- 40X - Other imaging services (except revenue code 403 – Screening mammogram);
- 46X – Pulmonary function;
- 471 – Audiology diagnostic;
- 48X - Cardiology, with CPT codes (includes but are not limited to): 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93545, 93561, or 93562;
- 53X – Osteopathic services;
- 61X - MRI;
- 62X - Medical/surgical supplies, incident to radiology or other diagnostic services;
- 73X – EKG/ECG;
- 74X - EEG; and
- 918 - Behavioral health treatment services, testing;
- 92X - Other diagnostic services.

Note: Any services, items and/or supplies that are integral to the performance of a diagnostic procedure also need to be combined with the inpatient admission. For example, pharmacy items and injections provided in conjunction with a diagnostic radiology procedure subject to the three day window, must also be combined with the inpatient account.

Non-Diagnostic Services: Services and supplies furnished as an integral, although incidental, part of a physician's professional service in the course of diagnosis or treatment of an illness or injury.

Related: ***Services are related when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the outpatient services and the inpatient stay.***

Wholly-owned or Operated: Any entity for which the hospital itself is the sole owner or the sole operator. The hospital need not exercise administrative control over a facility in order to operate it. An operator implements facility policies, but does not necessarily make the policies. Operating a facility simply involves conducting the facility's day-to-day activities, as opposed to "control," which involves the power to direct the facility's operations toward specific objectives.

Maintenance Renal Dialysis: Dialysis that is regularly furnished to an ESRD patient in a hospital-based, independent (non-hospital-based), or home setting.

PROCEDURE:

1. During the process of admitting a patient with Medicare Part A benefits, Patient Access staff must inquire if the patient has received outpatient services within the applicable "window" from an entity wholly-owned or operated by the admitting facility.

2. Patient Financial Services (PFS) personnel must review the Payment Window report on a daily basis to identify patients who have received outpatient services within the applicable "window" of an inpatient admission.

3. Outpatient services, which meet the criteria, as defined in the Policy section above must be combined with the inpatient admission. PFS personnel must contact the Health Information Management department to determine the appropriate code sequencing for the inpatient account.

4. Services noted on recurring patient types that do not meet the criteria in the Policy section above do not need to be combined to the inpatient admission. However, Occurrence Span Code 74 and the overlapping "from - through" dates of service must be entered in Form Locator 36 of the UB-04 for the outpatient recurring account.

5. If a Medicare Part A inpatient claim is denied or rejected due to overlapping outpatient services, and it is determined that the services submitted are subject to the Medicare payment window, PFS personnel must perform the following steps:

a. Perform a "void/cancel of prior claim" routine as soon as possible. (**Note:** Refer to the UB-04 Manual, for instructions on performing a Void/Cancel of Prior Claim.)
b. Combine the applicable charges from the outpatient claim to the inpatient claim. Refer to the Outpatient Services and Medicare Three Day Window Policy for instructions regarding combining ICD-9-CM procedure and diagnosis codes.
c. Re-bill inpatient claim once Medicare has taken back the outpatient void/cancel claim.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Billing Medicare OutPatient 3-day Window
Descriptive Type:	~~New~~ Revised Policy
Document Number:	11-3031
Attachments:	None
Author:	Christine Adams (Navigant Healthcare Cymetrix VP Revenue Cycle)/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	01/19/15
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Revision Date:	None
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Contractual Allowances and Routine Adjustments Policy

PURPOSE:

To establish guidelines for processing contractual allowances and adjustments and to ensure that the adjustments are being posted to the accounts accurately and timely.

POLICY:

Adjustments will be posted to the patient's account after the account is processed and the Patient Account Representative (PAR) determines that an adjustment is required to resolve the account. Adjustments that require an upper level approval will be forwarded appropriately.

PROCEDURE:

1. **(Posting Contractual Allowances)**
    a. Once a claim/bill has been received, final payment posting with all insurance dollars resolved (zero balance), it will be processed in the re-pricing tool to calculate any variance between the allowed per contract amount and the amount processed as allowed by the payer per the EOB.
    b. After the claim/bill is re-priced a data file is created that details the account number and variance amount (underpayment) which needs further pursuit with the insurance carrier.
    c. *The variance amount will be reviewed for further action with the carrier for additional payment or possible change to the account by a PAR to correct the claim for full claim payment upon reconsideration by the carrier.*
2. **Contract Management Team reporting to Tulare Finance Department**
    a. Contract Management team will report through the Revenue Cycle Director the results of variance work monthly for review with Tulare Finance leadership.
    b. Consistent claims errors and situations creating underpayment situations will be reviewed with appropriate service area management.
    c. Payer contracts showing consistent failure to pay up to TRMC expectation will be reported to TRMC Financial leadership.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Contractual Allowances and Routine Adjustments Policy
Descriptive Type:	~~New~~Revised Policy
Document Number:	11-3032
Attachments:	none
Author:	Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	01/19/15
Revision Date:	None
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Department Directors

FROM: Administration

SUBJECT: Overpayment Processing

OBJECTIVE:

To define a process for resolving credit balances and overpayments and to facilitate timely refunding of any confirmed overpayments.

POLICY:

Patient accounts with potential overpayments must be researched and analyzed promptly. If the payment discrepancy is confirmed as an overpayment, refunds must be made timely. In the case of confirmed overpayments due to federally-funded payers such as Medicare, Medicaid or TriCare. Refunds or adjusted claims must be processed within 60 days. In addition, in the case of federally-funded payers where credit balance reports must be filed with the payer and account adjustments or take-backs must be processed by the payer to resolve the overpayment, the specific payer rules and timeframes for processing must be followed. Based on payer specific guidelines, a refund may result in the form of an adjusted claim submission.

DEFINITION:

Credit balance/overpayment discrepancy – Credit balances and/or overpayment discrepancies can result from a payment made by an insurance carrier and/or another responsible party for an amount greater than expected duplicate payment/contractual entries, misapplied charges/credits, incorrect patient account adjustments, etc., posted as a financial transaction to the patient's account.

PROCEDURE:

The following steps must be performed to ensure timely research and analysis of patient accounts and prompt, accurate refunds of confirmed overpayments. Account discrepancies can occur for many reasons. Patient accounts with credit balances/overpayment discrepancies are to be researched to determine the reason for the account balance. These reasons may include an overpayment by an insurance carrier and/or another responsible party, duplicate payment/contractual entries, misapplied charges/credits, and incorrect patient account adjustments, etc. Once confirmed, all bona

fide overpayments must be promptly refunded to the appropriate patient, guarantor or third-party payer. In the case of federal payers, refunds must be made within 60 days of the confirmation, and based on payer specific guidelines, may result in the form of an adjusted claim submission.

IMPLEMENTATION

Operational Processes:
The Credit Balance Report, Unapplied Cash, and potential overpayment discrepancy report must be worked promptly. Any accounts in Bad Debt status should also be identified by running the appropriate queries.

1. Once the reason for the credit balance or overpayment discrepancy has been ascertained, proceed as follows:
   a. If the credit balance was caused by posting errors such as duplicate payment/contractual entries, misapplied charges/credits, or incorrect patient account adjustments, correct the balance.
   b. If a credit balance remains following correction of the posting errors, ascertain the party (*e.g.*, patient, guarantor, and third-party payer) entitled to the refund.
   c. Refund the balance promptly to the appropriate patient, guarantor or third-party payer. In the case of federal payers, refunds shall be made within 60 days of the confirmation, and based on payer specific guidelines, may result in the form of an adjusted claim submission. In the case of credit balances which have not been taken back prior to the end of each quarter, for payers such as Medicare, Medicaid or TriCare where credit balance reports must be filed with the payer and take-backs must be processed, the specific federal payer rules and timeframes must be followed. Medicare requires credit balance reports to be submitted quarterly (*i.e.,* the CMS-838 report).

      - If a refund is due to a Medicare beneficiary and the refund check has been returned by the postal service for an invalid address, review the fiscal intermediary online system as part of the attempts to determine the patient's address.

      - If a refund is due to the other insurers they should be contacted in a manner consistent with their policies/contracts.

      - If a refund is due to a federally-funded payer, they should be contacted in a manner consistent with their policies/contracts.

2. In order to comply with state unclaimed property laws, a reasonable effort must be made to locate the party who is due the refund. If a refund check remains un-cashed for eleven months, a written notice should be sent to the last known address of any party with a credit balance of $50.00 or more. The notice must inform the party that the

facility is in possession of property belonging to him or her and instruct the party on how to collect the property. This notice must be sent first class mail. If this attempt is unsuccessful, a second notice must be sent not more than 120 days and not less than 60 days before the unclaimed property is reported to the state. Copies of all notices must be retained for 15 years.

3. If efforts are not successful to refund the entire amount owed because of inability to locate the patient, guarantor or third-party payer to whom the refund is owed, the credit amount should be recorded to liability account (General Ledger) and a detailed log is to be maintained which supports the balance of the liability account. The log should include, at a minimum, the account number, the patient name, the party making overpayment, the address of party making overpayment, date of service and the date of the overpayment.

4. Where there is a continued inability to locate the patient, guarantor or the third party to whom the refund is owed, final disposition of the payment must be processed according to the applicable State Unclaimed Property Law.

It is the responsibility of the Patient Financial Services Office to ensure compliance with this policy.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Overpayment Processing
Descriptive Type:	~~New~~Revised Policy
Document Number:	11-3033
Attachments:	None
Author:	Christine Adams (Navigant Cymetrix VP Revenue Cycle/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	01/19/15
Revision Date:	None
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Unidentified Cash Posting

PURPOSE:

To ensure that the guidelines and procedures are followed to resolve all accounts that are in the unidentified cash accounts are resolved.

POLICY:

It is the policy that all accounts that are posted in the unidentified account be resolved by the end of each month.

PROCEDURE:

1. Cash that requires manual or electronic posting can be received in the following scenarios:
    a. Lockbox
        i. The lockbox will deposit the money, prepare the batch, and send the batches to Patient Financial Services (PFS) with the original EOB, and copies of the checks.
    b. Mailroom
        i. Mailroom delivers payments to PFS.
        ii. Cash posting sort's payment, copies checks, prepares the batch, and assigns a batch number.
    c. Electronic Remits
        i. Cash posting posts ERAs after funds have been deposited.
2. If cash is received through the lockbox or electronic remits procedure, then the cash poster will enter the batch number, total items to be posted, and the total dollars to be posted into the batch header for each batch received.

3. The cash poster posts the payment using the following identifiers:

    a. Visit ID: If patient is identified, the payment is posted to the account.
    b. Patient Name: If date of service matches, the payment is posted to the account.
    c. Patient Unidentified: payment is posted to unidentified cash.

4. Once all payments in the batch have been posted, the cash poster will finalize the batch in the Patient Accounting System.

5. The batch must balance. If the batch does not balance, the cash poster will perform a line item batch review to determine variance, and make corrections to either a line item, or the batch header.

6. If an account cannot be identified at the time of posting, the cash poster will post the cash to the unidentified cash account.

7. The cash poster will keep a daily log of the items posted to the unidentified cash account.

8. The cash poster will make every attempt to research the list of accounts in the unidentified cash account in order to post the cash to the correct accounts. The unidentified cash account should be reconciled and at a zero balance by month end.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Unidentified Cash Posting
Descriptive Type:	~~New~~Revsied Policy
Document Number:	11-3035
Attachments:	None
Author:	Christine Adams (Navigant Healthcare Cymetrix VP Revenue Cycle)/ Alan Germany (CFO)
Typist:	Melissa Arend
Creation Date:	01/19/15
Revision Date:	None
Revision Date:	03/05/18 Andrea Carrasco/Ena Menezes
Prev. Dist. Date:	None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : Finance Department

FROM : Administration

SUBJECT: Finance Charges

1. **DEFINITIONS**

   A. "ACCOUNT BALANCE" – Refers to an unpaid amount due and payable by the guarantor. It may include balances expected to be paid by a third party, such as an insurance company because the service may not be a covered benefit.

   B. "FINANCE CHARGE" – Refers to an amount added to the account balance monthly, based on a percentage of the account balance.

   C. "GUARANTOR" – Refers to the individual assuming legal responsibility for payment of an account.

2. **CONDITIONS**

   A. Account balances are due upon billing of the guarantor. Customary terms are payment in full within thirty (30) days of the billing date.

      NOTE: Although payment may be expected from an insurer and expectation of payment from the guarantor postponed, finance charges shall be assessed according to customary terms, except for the exclusion described in 3 D.

   B. Extended payment terms may be granted upon negotiation of a promissory note or payment arrangement agreement. Customary terms are payment in full of an installment payment within thirty (30) days.

   C. Account balances, or installments, not paid in full within thirty (30) days are considered delinquent.

3. **RATIONALE**

   A. The finance charge shall be established at ten percent (10%) per annum, or 0.833% per month, and assessed on the 25TH day of each month, or whenever monthly statements are issued.

B. All delinquent account balances shall be assessed a finance charge.

C. All promissory note balances shall be assessed a finance charge.

D. Exclusions

   a. All account balances expected from a third party payor covered under a public healthcare program, such as Medicare, Medi-cal, TCMS, Indemnity Insurance, etc.

   b. All account balances on administrative hold.

E. Assessment and collection of finance charges shall be in full accord with state and Truth in Lending regulations as applicable.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Finance Charges

Descriptive Type: Revised

Document Number: 11-5001

Attachments: None

Author: Lucy Reimche

Typist: Debra Campbell

Creation Date: 11/13/02

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

Prev. Dist. Date: 2/29/00

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~1/22/03~~	

Effective Date: ~~1/23/03~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Patient Refunds

In order to insure that credit balances that occur on patient accounts are processed in a timely manner, the following procedure has been established:

1. The patient/guarantor shall be reimbursed any amount actually paid in excess of the amount due.

2. Patient accounts should be reviewed for:

   A. Administrative and courtesy adjustments or errors.

   B. Verification of who made the payment(s).

   C. Correctness of payments received from the insurance company, and if insurance paid any interest due as stated by law.

3. The Patient Account Representative (PAR) is responsible for analyzing and resolving accounts.

4. If there are unpaid balances for previous services provided, overpayment will be applied to the open account(s) first.

5. If the account is reviewed and the PAR determines that a refund should be issued to the patient or third party payer, then the PAR will complete the following:

   a. Complete the facility's refund request form.
   b. Gathers back-up documents to accompany request form.
   c. Document notes in the Health Information System.
   d. Add the account details to the refund request spreadsheet.
   e. Scans refund request, back-up documents and refund request spreadsheet to Health Information System.

8. Print refund request packets from Health Information System and submit to management/CFO for approval.

9. Management/CFO approves refund and forwards to Accounts Payable for processing.

10. Accounts Payable issues checks and returns to management/CFO for signature.

11. Update refund request spreadsheet with check details, mails the check, and alerts the Patient Financial Services (PFS) department that the refund has been completed.

12. The PFS department will enter a note in the Health Information System with the check details and the mail date of the refund.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient Refunds and Credit Balances

Descriptive Type: Revised

Document Number: 11-5002

Attachments: None

Author: Christine Adams (Navigant Healthcare Cymetrix, VP Revenue Cycle)/ Alan Germany (CFO)

Typist: Andrea Carrasco/Ena Menezes

Creation Date: 11/13/02

Revised Date: 01/19/15

Revision Date: 03/05/18

Prev. Dist. Date: 01/27/11

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Self-Pay Prompt Pay Discount

PURPOSE:

To provide guidelines and processes for patients who are uninsured and are eligible for a self-pay discount on medical services.

POLICY:

To provide uninsured patients a 20% discount for prompt payment on an account. To provide, insured patients a 20% discount for any out of pocket expense paid within 30 days of service unless the discount is not permissible per the insurance contract.

PROCEDURE:

1. Review all patient/guarantor outstanding accounts with self-pay balances.
2. Contact the patient/guarantor via the telephone to arrange for payment of the account.
3. If patient/guarantor is contacted perform the following:
    a. Request payment in full of the account balance with a 20% discount.
    b. If patient/guarantor is unable to pay balance in full, request three equal payments. First installment due at time of call.
    c. If patient/guarantor is unable to make three equal payments and requests a longer payment period, establish a payment plan according to the payment plan policy.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Self-Pay Prompt Pay Discount

Descriptive Type: ~~New~~Revised Policy

Document Number: 11-5003

Attachments: None

Author: Christine Adams (Navigant Healthcare Cymetrix VP Revenue Cycle)/ Alan Germany (CFO)

Typist: Melissa Arend

Creation Date: 01/19/15

Revision Date: None

Revision Date: 03/05/18 Andrea Carrasco/Ena Menezes

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
~~(Tulare District HealthCare System) (TDHS)~~TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments and Employees

FROM: Administration

SUBJECT: ~~User Policy – Computer, Telephone, E-Mail, Voice-Mail and Internet Access~~Information Security Policy – Acceptable Use

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1. **Acceptable Use of TRMC Information, TRMC Networks, TRMC-owned Computing, Systems/Devices, TRMC-owned Medical Devices, and TRMC-owned Electronic Media**
   - **a.** TRMC provides workforce members with access to its information, networks, computing systems/devices, medical devices, and electronic media as necessary to allow workforce members to perform their jobs.
   - **b.** Incidental personal use by a TRMC workforce member of TRMC networks, TRMC computing systems/devices, or electronic media that is limited in frequency and scope is permitted so long as the use does not:
     - i. Interfere with the workforce member's work performance;
     - ii. Interfere with any other workforce member's work performance;
     - iii. Have an undue impact on the operation of TRMC's network or computing systems/devices (e.g. causes severe degradation of response time);
     - iv. Incur any additional costs to TRMC; or
     - v. Violate any other provision of this policy, any other TRMC policy, or applicable federal or state law.

2. **TRMC prohibits performing or attempting the following:**

   a. Tampering with or disabling security technical mechanisms, such as malicious program detection/remediation software or password-protected screensavers, on TRMC-owned computing systems/devices or medical devices, or on non-TRMC-owned computing systems/devices or medical devices connecting to the TRMC network, or storing, receiving, transmitting, or displaying TRMC information.
   b. Accessing without authorization TRMC files, directories, shared drives, or accounts.
   c. Using or disclosing TRMC information to conduct fraudulent, malicious, harassing or illegal activity, or using TRMC computing systems/devices or electronic media to conduct fraudulent, malicious, harassing, illegal, or personal activity.
   d. Using, selling, disclosing, divulging, distributing, or otherwise disseminating information or software owned by or licensed to a TRMC entity without first obtaining express written permission from TRMC CIO or designated representative.
   e. Copying software purchased or registered by TRMC, unless such action is permitted by the license agreement. Such copying may be done only with CIO's documented consent.

f. Posting TRMC information on the Internet or other public forum without documented management approval. This includes chats and texting.
g. Disclosing any non-public information of or about TRMC, its partners, vendors, or suppliers, without documented TRMC management approval. This provision covers electronic, photographic, spoken, or written information; and includes, but is not limited to:
    i. TRMC's current or future business performance, business plans, or prospects; and
    ii. Medical or business methodologies, procedures, research, or other intellectual property owned or used by TRMC.
h. Developing or implementing an Internet site that can be used by individuals or automated processes to access TRMC information or services, except with prior appropriate documented management approval and with TRMC's application security risk assessment requirements.
i. Engaging a third party to host an Internet site used by individuals or automated processes to access TRMC information or services, except with prior, documented management approval and in accordance with TRMC's application security requirements, including a written contract and BAA.
j. Using any TRMC information, computing system/device, or electronic media to defame, libel, abuse, or portray in a false light, TRMC or any of its business partners, affiliates, customers, patients, or workforce.
k. Using TRMC information, computing systems/devices, or electronic media to promote or maintain a personal business, for personal gain, to endorse any product or service, or to proselytize for religious causes.
l. Using TRMC information, computing systems/devices, or electronic media in any political campaign on behalf of, or in opposition to, any candidate for public office, or any other partisan political activities.
m. Using hardware or software tools intended to defeat software copy protection, discover passwords, identify security vulnerabilities, decrypt encrypted files, or to compromise information security on TRMC-owned computing systems/devices, or non-TRMC-owned computing systems/devices connecting to the TRMC network unless authorized in writing by TRMC CIO.
n. Writing, copying, executing, or attempting to introduce any computer code designed to self-replicate, damage, or otherwise hinder the performance of or access to any TRMC information, TRMC-owned computing systems/devices, or non-TRMC-owned computing systems/devices connecting to the TRMC network, or storing, receiving, transmitting, or displaying TRMC information.
o. Using TRMC-owned computing systems/devices or electronic media for non-work-related applications or software (e.g., games, streaming audio/video, mp3 players, flash drives, screensaver downloads) that can degrade TRMC network or computing system/device performance.
p. Installing surveillance (e.g. "spyware"), monitoring, peer-to-peer, or data-sharing software programs on TRMC-owned computing systems/devices, with the intent of tracking other workforce members' activities or using their computing systems/devices, unless the installation is authorized by TRMC management and performed by TRMC-IT.

q. Retaining information in an electronic format (e.g., on the TRMC network server, TRMC data center, on a workstation, mobile device, electronic media) in a manner that is not compliant with the TRMC Information Security Policy.
r. Accessing pornographic Internet sites, hate-based sites, hacker sites, or other websites that TRMC management determines will not be allowed. (Please note that some medical staff may need to access websites that deal with human sexuality as part of their jobs; this is not meant to restrict those legitimate activities.)
s. Posting, sending, or acquiring sexually explicit or sexually-oriented material, hate-based material, hacker-related material, or any other material that TRMC management has determined will not be allowed.
t. Using TRMC networks or TRMC-owned computing systems/devices to participate in non-work- related chat sessions, instant messaging (IM), texting, or other Internet-based discussion groups.
u. Sending, transmitting, or otherwise disseminating, or using TRMC information unless authorized by the employee's supervisor, or by a policy and procedure approved by TRMC.
v. Sending or distributing email in violation of federal or state laws, regulations, or TRMC policies or in a manner that otherwise creates a hostile work environment.
w. Sending chain letters or other mass emailing without TRMC management approval.
x. Workforce members may not initiate or forward chain email (i.e. a message sent to a number of people with the request that each recipient send copies of the same request to a specified number of others), unless authorized by management.
y. Using voicemail to make unauthorized broadcast messages or solicitations, or for any other purpose that is not authorized by TRMC policy or not compliant with applicable law.

3. **Ownership of TRMC Information:**
   - **a.** Electronic information created by workforce members or on behalf of TRMC, whether using TRMC-owned or non-TRMC-owned computing systems/devices, is the property of TRMC.
   - **b.** TRMC has right of access, as permitted by law, to TRMC information on non-TRMC- owned computing systems/devices, including backup files and archives.
   - **c.** Workforce members will securely erase TRMC information or other TRMC content from non-TRMC-owned devices when directed to do so or when the information or content is no longer needed for conducting TRMC business.

4. **Control of Internet Usage:**
   - **a. Permitted use:**
     - i. TRMC Internet connections and online services are provided for business purposes, performance of job-related functions, and professional training and education.
     - ii. Electronic communications and Internet access in furtherance of TRMC business activities with professional associates, colleagues, supplier representatives, and others.
     - iii. Incidental personal use of Internet services that does not impact the business. Incidental user includes, but not limited to:
       1. Short personal phone calls or emails

   - **b.** TRMC takes preventive action, including application of Internet access filtering software and devices, to block or deter access to any Internet sites that have been determined or are suspected of containing materials or services that are illegal, inappropriate to a business environment, or are detrimental to the operation of the TRMC network or computing systems/devices. Such sites include, but are not limited to, those which:
     - i. Are known sources of electronic attacks or malicious or disruptive code including, but not limited to, viruses;
     - ii. Contain or provide access to materials, e.g. pornography, of which viewing, or possession violates federal, state, or local law or TRMC policy;
     - iii. Are sites known to promote or provide access to illegal activities or to promote hate-based or hacker activities, or facilities for gambling;
     - iv. Are used for external (cloud) data storage without TRMC CIO approval and Security Risk Assessment.

   - **c.** To the extent that TRMC establishes filtering or blocking software that prevents access to a site needed for an approved business purpose, a TRMC workforce member may request restoration of a blocked site using TRMC's IT Ticketing system. The ticket must include business justification.

5. **Communications:**

Each employee is responsible for the content of all text, audio or images that he/she places or sends over Tulare Local Health Care District's communications network.

No e-mail or other electronic communications may be sent which hides the identity to the sender or represents the sender as someone else. All messages communicated on Tulare Local Health Care District's communications network must contain the employee's name.

Any messages or information sent by an employee to another individual outside of Tulare Local Health Care District via an electronic network (e.g., bulletin board, online service or Internet) are statements that reflect on Tulare Local Health Care District.

6. **Expectation of Privacy:**

TRMC reserves the right to access and monitor all messages and files on our communications network. Employees do not have an Expectation of Privacy when conducting TRMC Business or using TRMC assets.

~~This policy strictly prohibits any employee use of an unauthorized access code, accessing other computer files that the employee has no right to access, or any dissemination of confidential information that is derived from electronic or other sources.~~

~~All computer system networks, business and telephone equipment and other electronic communication systems, and all communications and stored information transmitted, received or contained in Tulare Local Health Care District's information systems are Tulare Local Health Care District's property and are to be used solely for job-related purposes. Tulare Local Health Care District may monitor such use on a random basis to see that such equipment is used for its proper purposes. Tulare Local Health Care District strictly prohibits non-job related uses of its software and business equipment, including, but not limited to telephone systems, telecopiers, computers, copy machines and facsimiles. Employees are also prohibited from using codes, accessing files, or retrieving any stored communication without prior clearance from an authorized Hospital representative. No employee may use a pass code unknown to Tulare Local Health Care District. The existence of an employee pass code or password does not mean that messages sent using a password or passcode will be confidential.~~

~~ACCEPTABLE USES OF HOSPITAL SYSTEMS:~~

~~Tulare Local Health Care District-provided computer and telephone system with its Internet, e-mail and voice-mail access is intended for business use only. Tulare Local Health Care District encourages the use of the computer and telephone system with its Internet, e-mail and voice-mail access, because it makes communication more efficient and effective. However, the computer and telephone system with its Internet e-mail and voice-mail access is Hospital property, and its purpose is to facilitate Tulare Local Health Care District's public image. Employees are required to use the computer and telephone system with its Internet, e-mail and voice-mail access in a productive businesslike manner. Games are prohibited, even during break or mealtime. To ensure that all employees are responsible, the following guidelines have been established for using the computer and telephone system with its Internet, e-mail and voice-mail access. Any improper use of the computer and telephone system with its Internet, e-mail and voice-mail access is not acceptable and will not be permitted.~~

~~UNACCEPTABLE USES OF HOSPITAL SYSTEMS:~~

~~E-mail networks and voice-mail shall not be used to solicit for outside business ventures, organizational campaigns, and political or religious causes. Any use of such equipment for inappropriate or offensive messages is prohibited. The policy is also violated when users break into confidential files or otherwise abuse the privilege of computer access, or abuse the system~~

Effective Date: ~~7/24/03~~ (11) ~~—~~Data Process Information Services:

Approved:

~~Computer,~~

Board of Directors: ~~7/23/03~~

~~User~~Information Security ~~–~~ Policy – Acceptable Use ~~Telephone, E-Mail, Voice-Mail~~ and ~~Internet Access~~

11-6004

by unauthorized surfing. Unauthorized use of e-mail or voice-mail for non-business purposes is also strictly prohibited.

Tulare Local Health Care District's computer and telephone system with its Internet, E-mail and voice-mail access may not be used for transmitting, retrieving or storage of any communications of a discriminatory or harassing nature or materials that are obscene or X-rated. Harassment of any kind is prohibited. No messages with derogatory or inflammatory remarks about an individual's race, age, disability religion, national origin, physical attributes or sexual preference shall be transmitted. No abusive, profane or offensive language is to be transmitted through Tulare Local Health Care District's computer and telephone system with its Internet, e-mail and voice-mail access. Electronic media may also not be used for any other purpose which is illegal, against Hospital policy or contrary to Tulare Local Health Care District's best interest. Solicitation of non-hospital business or any use of Tulare Local Health Care District's computer and telephone system with its Internet, e-mail and voice-mail access for personal gain is prohibited.

Employees are also prohibited from accessing, distributing or publishing through the use of Hospital equipment, any confidential information, trade secrets or other proprietary information of Tulare Local Health Care District without proper authorization.

In addition, all employees are prohibited from down loading, viewing, transmitting, and/or possessing pornographic, profane, sexually explicit, or racially offensive materials from Hospital equipment or systems.

COMMUNICATIONS:

Each employee is responsible for the content of all text, audio or images that he/she places or sends over Tulare Local Health Care District's computer and telephone system along with its Internet, e-mail and voice-mail access. No e-mail or other electronic communications may be sent which hides the identity to the sender, or represents the sender as someone else or someone from another Hospital. All messages communicated on Tulare Local Health Care District's computer and telephone system with its Internet, e-mail and voice-mail access must contain the employee's name.

Any messages or information sent by an employee to another individual outside of Tulare Local Health Care District via an electronic network (e.g., bulletin board, online service or Internet) are also statements that reflect on Tulare Local Health Care District. While some users include personal "disclaimers" in electronic messages, there is still a connection to Tulare Local Health Care District and the statements may be tied to Tulare Local Health Care District.

SYSTEMS VIRUS:

To prevent computer viruses from being transmitted through Tulare Local Health Care District's Internet and e-mail system, there will be no unauthorized downloading of any unauthorized software. All software downloaded or loaded from a disc onto a computer must be registered to Tulare Local Health Care District and approved through the Information Services Department. Employees should contact IS if they have any questions.

TRANSMISSION OF COPYRIGHT MATERIALS OVER HOSPITAL SYSTEMS:

Copyright materials belonging to entities other than this Hospital may not be transmitted to employees over Tulare Local Health Care District's e-mail/Internet system. All employees obtaining access to other companies' or individuals' materials must respect all copyrights and may not copy, retrieve, modify or forward copyright materials, except with permission, or as a single copy to reference only. Failure to observe copyright or license agreements may result in disciplinary action up to and including termination.

PROTECTION OF HOSPITAL SYSTEMS SECURITY:

All employees are hereby put on notice that telephone calls and usage patterns for its e-mail/Internet communications may be monitored. All messages created, sent or retrieved over Tulare Local Health Care District's e-mail/Internet are the property of Tulare Local Health Care District and should be considered as being in the public domain notwithstanding the employee using a personal access code. Tulare Local Health Care District reserves the right to access and monitor all messages and files on Tulare Local Health Care District's e-mail/Internet and voice-mail system. Employees should not assume electronic communications are private and should transmit highly confidential data in other ways. All employees are put on notice that system security features, such as passwords and message delete functions, do not take away the ability to archive any message, at any time, for future viewing. Electronic and voice-mail communications are subject to search without notice.

VIOLATIONS:

Employees who violate this policy are subject to discipline up to and including termination, depending upon the seriousness of the offense in the judgment of management. All employees will be required to sign a form acknowledging their understanding and compliance with this policy (**see attached)**. Tulare Local Health Care District also reserves the right to advise appropriate legal officials of any illegal violations.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

~~Information Systems Department Usage Agreement~~

~~Tulare Local Health Care District (hereinafter TLHD) has installed Information Systems allowing computerization of information. The utilization of the automated systems will communicate information to authorized users more effectively, leading to quality improvement in patient care. In order to protect the information contained in the TLHD databases and to prevent unauthorized use of all information, access to the Information System will be limited to those persons who are issued an access code by TLHD. The issuance of an access code is subject to the following usage agreement.~~

~~In consideration of the issuance of an access code to the Information Systems of TLHD, I, the undersigned, agree to the following:~~

1. ~~The access code issued to the undersigned is the equivalent of the undersigned's legal signature, and the undersigned agrees to be held accountable for any/all access to the information, including any peripheral systems which are accomplished by means of this access code.~~

2. ~~The Information Systems contain confidential data and any disclosure of this data or other information is subject to the Confidentiality policy (15-2071), Release of Information – Patient, Medical and/or Medical Records policy (13-9001) and Code of Ethical Behavior/Code of Conduct Principles policy (10-1002.1) as set forth in TLHD Administrative Policy Manual, latest revised.~~

3. ~~The undersigned will not disclose the access code to anyone nor allow its use by another person.~~

4. ~~The undersigned will not attempt to learn another person's access code nor access the information by using any other access code other than the access code assigned to the undersigned.~~

5. ~~The undersigned will not access the Information System to obtain any information or other data for whom the undersigned has no responsibility or for whom the undersigned has no "need to know" in keeping with the policies listed in item #2.~~

6. ~~If the undersigned has reason to believe that the confidentiality of the access code, or any other access code has been compromised, the undersigned will contact the Information Services to ensure that a new access code is issued.~~

7. ~~The undersigned agrees to remain in compliance with Policy #11-6004 User Policy – Computer, Telephone, E-mail, Voice Mail and Internet Access.~~

~~The following points are to be followed, in order to comply with TLHD license agreements with its software vendors:~~

- ~~TLHD will use all software in accordance with license agreements.~~

~~Legitimate software will be provided to employees when identified as a requirement of their~~

~~position.~~

- ~~TLHD does not condone illegal copying of software under any circumstances. Any person illegally reproducing software can be subject to civil and criminal penalties, including fines and imprisonment.~~
- ~~No employee of TLHD shall make any unauthorized copies of any software under any circumstances. Anyone found copying software will be subject to disciplinary action and possible termination.~~
- ~~TLHD will not tolerate the use of unauthorized copies of software in the company (i.e., programs from home, vendor's demos, another company's software, 'shareware', etc.).~~
- ~~No employee shall give licensed software to anyone not employed by TLHD.~~
- ~~Any employee who determines that there may be a possible misuse of software within TLHD shall notify the Information Systems Department immediately.~~
- ~~Because of system compatibility issues and software licensing policies, all software to be used on TLHD computer networks or systems must be approved AND acquired through the Information Systems Department.~~

~~Any violation of this Agreement or other misuse or abuse of any Information System and/or the undersigned's access code will be treated as a violation of the policies, procedures, practices and philosophy of TLHD and may subject the undersigned to corrective actions, up to and including termination, in keeping with established Human Resources policies.~~

~~"I have read the above conditions and understand the policies; I agree to abide by these policies set forth by Tulare Local Health Care District~~

~~EMPLOYEE'S NAME (print)_____~~

~~EMPLOYEE'S SIGNATURE_____ DATE_____~~

~~Information Systems Department Usage Agreement~~
~~External Entities/Non-Disclosure~~

~~Tulare Local Health Care District (hereinafter TLHD) maintains Information Systems which allow computerization of confidential information. In order to protect the information contained in the TLHD databases and to prevent unauthorized use of all information, access to the Information System is limited to those persons who are issued an access code by TLHD. The issuance of an access code is subject to the following usage agreement.~~

~~In consideration of the issuance of an access code to the Information Systems of TLHD, I, the undersigned, as the authorizing agent for myself and my employees and contractors, (Authorized User), agree to the following:~~

1. ~~The access code issued to the Authorized User is the equivalent of the Authorized User's legal signature.~~

2. ~~The Information Systems contain confidential data and any disclosure of this data or other information to unauthorized personnel will automatically entitle TLHD to terminate any, or all contractual agreements with Authorized User at TLHD's sole discretion.~~

3. ~~The Authorized User will not disclose the access code to anyone other than the designated authorized employee or contractor, nor allow its use by another party.~~

4. ~~The Authorized User shall not attempt to learn another person's access code nor access the information by using any other access code other than the access code assigned to the Authorized User.~~

5. ~~The Authorized User shall not access the Information System to obtain any information or other data for which the Authorized User has no "need to know".~~

~~If the Authorized User has reason to believe that the confidentiality of the access code, or any other access code, has been compromised, the Authorized User will immediately notify the Information Services at (559) 685-3409, and obtain a new access code.~~

6. ~~The Authorized User agrees to indemnify, defend, and hold harmless TLHD against any and all claims or demands, including attorney fees incurred in defending any actions filed for the unauthorized release of confidential data by its employees or agents.~~

~~Any violation of this Agreement or other misuse or abuse of any Information System and/or the Authorized User's access code will be treated as a violation of this usage agreement and may subject the Authorized User to termination of any or all contracts , in addition to other remedies available under California law.~~

~~"I have read the above conditions; I agree to abide by these terms set forth herein by Tulare Local Health Care District.~~

~~ENTITY NAME~~ _____

~~ENTITY ADDRESS~~ _____

~~ENTITY TELEPHONE~~ _____

~~Authorizing Agent (Print)~~ _____

~~Authorizing Agent's Signature~~ _____~~Date~~_____

Descriptive Name:	~~User Policy – Computer, Telephone, E-Mail, Voice-Mail and Internet Access~~Information Security Policy – Acceptable Use
Descriptive Type:	Revised
Document Number:	11-6004
Attachments:	~~Included~~None
Author:	~~John Clark~~Dan Sedano
Typist:	~~Debra Campbell~~Dan Sedano
Creation Date:	11/13/02
Prev. Dist. Date:	1/17/00

Committee Review and Approval	Approval Date	Comments
Board of Directors		

~~Revision Notes: General Board 7/23/03~~

Effective Date:	~~7/24/03~~
Forward To:	Policy Binders – (~~5,~~PBX and Administration) and Post on Intranet ~~Site~~
Disposition:	Copy and distribution – ~~Debra Campbell~~Administration
Comments:	~~Send 200 copies of Memo with list of policies approved by Board of Directors to HR for payroll distribution.~~

~~Date Completed: 7/25/03~~

TULARE LOCAL HEALTHCARE DISTRICT
dbaTULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Information ~~Services~~ Security Program and Governance ~~Officer~~

~~Policy:~~

~~All computer access security is maintained by Information Services. Security access to stand alone or designated systems may be maintained by the departmental personnel responsible for the data integrity of the designated system, however, the procedures for gaining, maintaining and relinquishing access outlined in this policy and procedure must still be followed.~~

~~Departmental personnel responsible for security on stand-alone or designated systems must receive written confirmation from Information Services before establishing passwords or other security codes, and must follow this policy and procedure.~~

~~New Employees:~~

~~User ID's and passwords are activated only after receipt of Computer Security Access Form (CSAF) approved by Human Resources. Forms are sent to techdesk@tdhs.org only from approved Human Resources personnel. Passwords will be set to expire and will force user to change upon first sign on. Passwords will expire every ninety days.~~

~~Vendor or Contract requiring access:~~

~~User ID's and passwords are activated only after receipt of Computer Security Access Form (CSAF) approved by Human Resources. Forms are sent to techdesk@tdhs.org only from approved Human Resources Personnel. In addition, Information Services staff will verify contract and BA agreement is on file with Administration and active. Passwords will be set to expire and will force user to change upon first sign on. Passwords will expire every ninety days.~~

~~Additional access;~~

~~In cases of employees needing additional access within the same department, it is the responsibility of the department Director to send Information Services notification of the additional access needed to techdesk@tdhs.org~~.

~~**Transfers:**~~

~~In cases of employees transferring departments, it is the responsibility of Human Resources to send Information Services an updated Computer Security Access Form (CSAF) to techdesk@tdhs.org with the old department and new department information.~~

~~**Terminations:**~~

~~Human Resources will send termination information to Information Services at techdesk@tdhs.org with the expected termination date, employee name and Director's name of terminating employee. Information Services department will process these terminations on same day of termination.~~

~~In instances of abrupt terminations, Human Resources department will notify Information Services by phone for immediate termination of user accounts at X3614.~~

~~**Periodic Audit:**~~

~~The Information Services Department, in conjunction with the Human Resources Department, will periodically, but no less often than annually, conduct an unannounced audit of access authorization and use to ensure the practices outlined in this policy and procedure are followed. The audit will encompass at least a sample of 5% of authorized users annually.~~

~~Questions concerning any aspect of this policy/guideline should be referred to Administration.~~

~~This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.~~

Data Processing (Information Services)

Date: _____

Please ensure all items are filled out correctly. All required fields must be filled in with valid data or this form will be rejected. Send all CSAF and related requests to Human Resources

_____

Employee Information

First:	_____	MI:	_____	Last:	_____

_____

Employee Number ***(optional):*** _____

Position/Title ***(required):*** _____

Department Name ***(required):*** _____

_____

Employee Start Date: ***(required):*** _____

Extension # ***(required):*** _____

(Check one only *required*) New Employee Existing Employee Existing Employee
_____ (No Account) (Change Account) _____
_____

Full Name of primary "match" employee ***(required)***: _____

Match employee ID# ***(required)***: _____

Full Name of secondary "match" employee ***(required)***: _____

Match employee ID# ***(required)***: _____ .....

Check here if Employee is changing departments ***(check one - required)***: YES NO

If employee is changing departments, fill out the following ***(required if 'yes' checked above)***

Old department.....

New department.....

AS/400 – Check all that apply:

_____ Employee will use HMS (AS400)

_____ Employee will need Order Entry

Employee will need Charge Entry

Employee will need Time and Attendance

AS/400 – Continued:

Employee will need Managers Financials.

List all AS400 menu items that this employee will need in addition to those of "match" employee shown above (General Ledger, Patient Accounting, Etc.):

Network/Windows – Check all that apply:

Employee will use a PC and have Network Access ***(required)***

Employee will have access to Outlook Calendar and E-Mail (optional)

Employee will need access to CSI system **(Evolutions and Finance departments *only*)**

Employee will need access to OBIX system **(OB and HIM departments only)**

Employee will need access to Orchard system **(Laboratory department only)**

Employee will need access to PACS system **(Clinical departments only)**

List all Public Folders, Calendars, Contact Lists, Security Groups, Drives, and Distribution Lists this Employee needs access to (in addition to "match" employee shown above) ***(required)***:

Special Access Options:

List all other access, menus, or special needs to be **added** or modified for this employee:

List all other access, menus, or special needs to be **removed** from this employee:

APPROVALS:

Supervisor/Department Head ***(required)***:

Approved:

HR Use Only:

Signature / Sender:

Updated 01/24/2009

1. **Policy:** TRMC demonstrates its commitment to the protection of its information, networks, computing systems/devices, medical devices, and applications through the operation of an enterprise-wide Information Security Program.

    a. TRMC Information Security Program and Governance is supported by executive leadership of Tulare Regional Medical Center (TRMC) and its Board of Directors. These bodies ensure the program is supported by appropriate resources and is integrated throughout the enterprise.

2. **Responsibilities:**

    a. The Information Security Officer (ISO) will be appointed in writing and communicated to the workforce. The ISO is responsible for functions related to TRMC's Information Security Program, including but not limited to:

        i. Managing the Information Security Program;
        ii. Collaborating with TRMC Compliance, Change Management, and regulatory organizations, monitoring, developing programs to comply with, preparing for, and responding to changes in legal, regulatory, and business requirements that may impact the Information Security Program;
        iii. Monitoring and reacting to technological advancements that may impact the Information Security Program;
        iv. Development of security strategy, goals, and objectives;
        v. Development and management of security policies and standards;
        vi. Supporting TRMC security architecture and security tools;
        vii. Managing security risks and vulnerabilities;
        viii. Consultant to Training Office for security awareness, communication, and training;
        ix. Approving authority for selection and implementation of security solutions;
        x. Approving authority for exceptions to Security Policies or procedures;
        xi. Overseeing identity and access management processes;
        xii. Managing security events and metrics; and
        xiii. Periodically report to leadership TRMC's Security Posture.

    b. Department Managers and TRMC Information Technology (TRMC-IT) are accountable for the implementation and execution of technical and operational processes necessary to support the Information Security Program, its mission and the objectives of the program.

    c. Executive leadership, including Medical Directors and Nurse Supervisors are expected to:

        i. Champion TRMC's information security policies and practices;
        ii. Enforce compliance with applicable policies and practices and;
        iii. Reinforce security awareness to the workforce.

    d. TRMC workforce members are responsible for understanding and complying with TRMC information security policies and practices applicable to their role and job functions. They are responsible for reporting unsecure practices to their manager or to the ISO.

~~D~~escriptive Name:	Information ~~Services~~ Security ~~Officer~~Program and Governance
Descriptive Type:	Revised
Document Number:	11-6005
Attachments:	None
Author:	~~Rod Davison~~Dan Sedano

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Typist: ~~Julie Gresham~~Dan Sedano

Creation Date: 01/26/09

Revision Date: 3/9/18

Prev. Dist. Date: 09/26/02

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders – 5 and Post to Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba (Tulare District HealthCare System) (TDHS)TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: **Computer Backup**Information Security Policy – Data Storage and Back Up

Information Services maintains the backup for computer systems physically located in the Information Systems departments. All servers are backed up daily. Servers not located in the Information Services department are the responsibility of the department manager where the server is physically located. The AS/400 and all PC Servers have RAID protection. Backups for 'mission critical systems', such as HMS, are retained for a minimum of 3 weeks. The content of the backup is verified each business day. Full System backups are performed approximately once each quarter, and the tapes are rotated every other time. Month-end backups are performed on the 1st of each month for critical data and tapes are retained offsite for 1 year. G/L, AP, and Financial Calendar Year Ends are performed at the beginning of each calendar year (on or around January 1). These tapes are retained indefinitely. G/L, AP, and Financial Fiscal Year Ends are performed at the beginning of each new fiscal year (on or around July 1). These tapes are retained indefinitely.

Backups for 'less critical systems' are retained for a minimum of 1 week. Backups are verified for completeness, but not content. Monthly backups are performed each month and the tapes are retained offsite for 1 year. Yearend backups are not performed for less critical systems.

All backup tapes are to be kept in separate secured locations away from the AS/400 and servers. Individual managers also have the responsibility to maintain the tapes in a secured location away from their servers. (Preferably a different building)

Individual users wishing to have specific data backed up should maintain that data on their department or personal network drives. Individual local machines will not be part of normal backup procedures.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 1/23/03 (11) Fiscal & Business: Data Processing (Information Services)Information Security Policy

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Approved: ~~**Computer Backup**~~Data Storage and Back Up

11-6006

Board of Directors: ~~1/22/03~~

1. TRMC-Owned Systems/Devices.

a. TRMC-IT-Supported Computing Systems/Devices.

i. TRMC creates and maintains backup copies of essential electronic information that is stored on TRMC-IT-supported computing systems/devices to permit TRMC to continue its business functions in case of loss, damage, or destruction of the original information.

ii. Backups should be created often enough, and include sufficient data, to allow for a full restoration of essential electronic information in the event of primary data loss or corruption.

iii. TRMC-IT creates a retrievable, backup copy of essential electronic information, when needed, before moving any TRMC-IT-supported computing system/device on which the information is stored.

iv. Backup copies of essential electronic information are stored at secure offsite locations approved by TRMC.

v. TRMC-IT reasonably safeguards backup copies of essential electronic information by various appropriate means, including encryption, physical and electronic access controls, secure transport, and contractual agreements with offsite storage business entities.

vi. TRMC-IT will periodically test the process for restoring backup copies of essential electronic information and verify that recovery is successful.

b. TRMC Medical Devices.

i. Whenever the nature of a medical device permits, the Biomedical department, with assistance from TRMC-IT, will create and maintain backup copies of essential electronic information stored on medical devices necessary for TRMC to continue its business functions in case of loss, damage, or destruction of the original information.

ii. Whenever the nature of a medical device permits, the responsible TRMC business manager, with assistance from TRMC-IT, will create a retrievable, backup copy of essential electronic information, when needed, before medical devices on which the information is stored are moved.

iii. The Biomedical Department and department managers will work with TRMC-IT and medical device vendors to establish secure backup processes for essential electronic information, up to and including secure offsite storage if applicable.

iv. The responsible TRMC business manager is accountable for implementing reasonable safeguards for backup copies of essential electronic information by appropriate means, including encryption, physical and electronic access controls, secure transport, and contractual agreements with offsite storage business entities.

v. The responsible TRMC business manager will periodically test the restoration process for backup copies of essential electronic information and verify a successful recovery.

c. Business-Supported Computing Systems/Devices.

i. The responsible TRMC business manager creates and maintains backup copies of essential electronic information that is stored on business-supported computing systems/devices to permit TRMC to continue its business functions in case of loss, damage, or destruction of the original information.

ii. The responsible TRMC business manager creates a retrievable, backup copy of essential electronic information, when needed, before moving computing systems/devices on which the information is stored.

iii. Backup copies of essential electronic information are stored at secure offsite locations approved by CIO and TRMC-IT.

iv. The responsible TRMC business manager reasonably safeguards backup copies of essential electronic information by various appropriate means, including encryption, physical and electronic access controls, secure transport, and contractual agreements with offsite storage business entities.

v. The responsible TRMC business manager must periodically test the restoration process for backup copies of essential electronic information and verify that recovery is successful.

2. Non-TRMC-Owned Computing Systems/Devices.

a. If an original copy of TRMC essential information is not stored or maintained on a TRMC- owned computing system/device the TRMC workforce member who is using the non-TRMC-owned computing systems/devices must move all TRMC essential electronic information to a TRMC computing system/device or storage as soon as is practicable or when no longer needed for conducting TRMC business. This includes Cloud Storage such as OneDrive, OneNote, Google Drive, and any web-based email systems not maintained by TRMC-IT. Permanent Storage of TRMC data on non-TRMC systems is forbidden.

3. **Sarbanes-Oxley Act of 2009 (SOX) Financial Application Provisions.**
   - **a.** TRMC restores a sample of key SOX financial backup data annually. TRMC documents this process and validates the data for completeness. If this information is maintained by eternal vendor, the vendor will attest they follow this requirement.
   - **b.** TRMC business managers review backup copies from SOX financial applications annually and verify that the copies of data are readable.
   - **c.** TRMC-IT verifies that backup jobs for SOX financial applications are approved prior to being scheduled in production.
   - **d.** TRMC-IT monitors SOX financial application backup jobs, documents failures, and resolves any failures.
   - **e.** TRMC Business Manager conducts an annual inventory of offsite SOX financial application backup data and reviews the collection for accuracy and completeness.
   - **f.** TRMC Business Managers will review workforce member access to SOX financial application backup data quarterly. This review is conducted to ensure access levels are appropriate for job functions and must be adjust where necessary.
4. **Cardholder Data/Credit Card Information.**
   - **a.** Cardholder data/credit card information is never backed up; it is retained in approved storage only until the relevant transaction process is complete.

Descriptive Name: ~~Computer Backup~~Information Security Policy~~-~~ Data Storage and Back Up

Descriptive Type: Revised

Document Number: 11-6006

Attachments: None

Author: ~~John Clark~~Dan Sedano

Typist: ~~Debra Campbell~~Dan Sedano

Creation Date: 2/6/02

Revision Date: 3/9/18

Prev. Dist. Date: 12/22/99

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

R~~evision Notes: General Board 1/22/03~~

Effective Date: ~~1/23/03~~

Forward To: Policy Binders – 5 and Post on Intranet

Disposition: Copy and Distribution – ~~Debra Campbell~~Administration

Comments:

~~Date Completed: 1/24/03~~

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: ~~TechDesk Guidelines – How to Contact Support for IS Services.~~Information Services: Help Desk & Support

~~PURPOSE:~~

~~How and when end-users should contact Information Services support. Tulare Regional Medical Center consists of all hospital staff, full-time, part-time, contract or other with a business requirement of interacting with one of the IT resources. A validated end-user must have the appropriate security access rights to the resource issue being reported. By ensuring all end-users are valid end-users, patient safety and information security are not compromised.~~

~~1.0 End-User Call Ticket Guidelines~~

~~During the regular and expected operation of hospital IT resources, end-users may find it necessary to request assistance when presented with a resource issue. A technical issue or "call-ticket" begins when the end user first experiences the issue and ends when the end user is satisfied with the terms of the resolution presented by the On-Call Technician.~~

~~1.0.1 Prior to using any IT resource the end user is responsible for undertaking applicable training and certification where required. End-users who have not been trained are not valid end users for the purpose of IT support. Untrained end-users who do not have a firm grasp of the technology can cause a lack of productivity by engaging TechDesk staff with "non-issues."~~

~~1.0.2 Prior to engaging technical staff, end users should take notes or otherwise be able to recreate the issue and explain it thoroughly. End-Users should also be able to explain to the support staff what the process they took before the problem arose.~~

~~1.0.3 Valid end users should first request assistance from department training staff or super-user staff that may be able to resolve the issue quickly at the department level.~~

~~1.0.4 If intradepartmental resolution fails, it will be necessary for end users to contact the TechDesk or On-Call technician via telephone or e-mail.~~

~~1.0.5 Though call priorities are governed by criticality end users can request a call to be escalated, they must initiate the request at the time of ticket creation. Technicians will make every effort to accommodate the request where such request does not interfere with other high priority issues~~.

Effective Date: ~~03/26/09~~

(11)

Information Services:

Information Services –

APPROVED:

~~TechDesk Guidelines~~**Help Desk & Support**

11-6009

Board of Directors: ~~03/25/09~~

1.0.6 In cases where call priorities conflict, the end user may opt to discuss the issue with the Director of Information Services or the Nursing Supervisor during On-Call hours.

1.0.7 In cases where a technician must respond to the end user location, the end user should be flexible when scheduling the meeting time as TechDesk and On-Call technicians may have multiple calls to respond to.

1.0.8 End users should be attentive when the technician responds and should be open to training should resolution require system instruction.

1.0.9 End users must confirm satisfaction for all resolutions. If in fact the technician closes the call before resolution it will be reopened upon notification.

1.0.10 When received, end users must respond to periodic call satisfaction surveys sent from the Director of Information Services. Surveys will be used to improve TechDesk operations and Customer Service.

1.1 End-User Contact Options

The Information Services department reserves the authority to set and maintain the TechDesk contact schedule in accordance with hospital policy and with technician resource availability. With the exception of providing 24 hour coverage, all schedules can change at any time at the discretion of the Director of Information Services.

1.1.1 **Weekdays: 07:00 - 17:30**
TechDesk manned on-site
Usually immediate response
Non priority contact method: **E-mail (techdesk@tdhs.org)**
Priority contact method from with the hospital: **Telephone (x3614)**
Priority contact method from outside the hospital: **Telephone (559-684-4500)**

1.1.2 **Weeknights: 17:31 - 06:59**
Weekends & Holidays: 24 hours
TechDesk manned by on-call staff
Up to 10 minute response time (usually immediate)
Up to 60 minute on-site response (when required)
Non priority contact method: **E-mail (techdesk@tdhs.org)**
Priority contact method with the hospital: **Telephone (x3614)**
Priority contact method from outside the hospital: Telephone **(559-684-4500)**

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

1. **PURPOSE:**

Communicate TRMC-IT ticketing and support program.

2. **End-User Helpdesk Support**

a. A validated end-user must have the appropriate security access rights to the resource issue being reported to ensure all users are authorized and that TRMC sensitive information will not be compromised.

b. A "Support ticket" begins when the end user first reports the issue to the TRMC Help Desk and ends when the end user is satisfied with the resolution. The user will receive periodic notifications as to the status of the ticket. TRMC's Help Desk is the first level of support and should always be contacted first.

a. Prior to engaging the Help Desk, end users should take notes and be able to articulate the issue thoroughly. End-Users should be able to explain what they were doing before the problem arose and can be contacted if further clarification is needed. Users must understand and communicate the severity of the issue to the Help Desk.

b. Users should not contact on-site support directly unless it is a severity 2 or 1 incident and the Help Desk is unreachable.

c. Support Tickets are addressed by priority.

I. Severity 4- Normal priority. Trouble impacts one user, or user needs assistance with a common issue. Call the Help Desk.

II. Severity 3- Moderate Priority. May impact a few users within a department. Not Care Delivery related. Call the Help Desk.

III. Severity 2- Wide spread outage impacting more than one department. Not care Delivery related. Call the Help Desk. Local support will be notified immediately by the Help Desk. After hours On-Call will be dispatched after 5pm local.

IV. Severity 1- Care Delivery related. All care related issues are the highest priority. Call the Help Desk, Local support will immediately be notified by the Help Desk. After hours On-Call will be dispatched after 5pm local.

Descriptive Name: ~~TechDesk Guidelines – How to Contact Support for IS Services~~Information Services: Helpdesk & Support

Descriptive Type: ~~New~~ Revised Policy

Document Number: 11-6009

Attachments: ~~Yes~~

Author: ~~Rod Davison, Director of Information Services~~Dan Sedano

Typist: ~~Julie Gresham~~Dan Sedano

Creation Date: 2/08/09

Revision Date: 3/9/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders – 5 – Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Information ~~Management Planning Council – Support of Information~~ Security Policy- Change Management and Governance

~~PURPOSE:~~

~~1. Tulare Regional Medical Center has formed the Information Management Planning Council to assist the facility in maintaining software compatibility, hardware compatibility, reduction of system duplication, security of networks, and efficiency and effectiveness in information management.~~

~~2. The information Management Planning Council will be comprised of a cross section of personnel including Executive Staff, Chief Compliance/Quality Officer, Financial and Clinical Division, and other hospital personnel including Information Services staff.~~

~~PROCEDURE:~~

~~1. The Department Director shall complete and forward a new System Concept Document (see attachment A) to the Director of Information Services.~~

~~2. The Director of Information Services will handle the request internally or delegate the System Concept Document to the Information Management Planning Council.~~

~~3. The Information Management Planning Council will perform the necessary steps to either approve or deny the System Concept Document and make recommendations back to the Director of Information Services. The primary tools for this approval shall be the hospital System Development Life Cycle process which provides instructions to fully scope each system life cycle from concept and financial approval to implementation and maintenance.~~

~~4. The Chief Compliance/Quality Officer shall review the request to ensure the system is compliant with current hospital policy as well as local, state and federal law.~~

~~EXCLUSIONS:~~

~~1. This policy does not pertain to request which do not require Information Services~~

personnel, software or telecommunication resources. Any natural disaster or hospital emergency deemed by the Chief Executive Officer or his/her designee.

HARDWARE AND SOFTWARE STANDARDS:

1. In cooperation with Department Directors, the Director of Information Services or the delegated Information Management Planning Council shall strive to standardize the computer hardware and software across the enterprise to the extent operationally practicable. Exceptions will be made only in extraordinary cases where justified and deemed essential to the hospital mission, and when approved by the Director of Information Services.

MAINTENANCE CONTRACTS:

1. The Director of Information Services shall have the right and the responsibility to negotiate, on behalf of the hospital, appropriate contractual agreements for the maintenance, replacement and repair of equipment used across organizational lines and, where such agreements exist, provide a primary point of contact for coordinating service call placement, follow-up, and approval of vendor billing. Each unit shall bear its proportionate share of the cost of such contracts.

SUMMARY:

1. No vendor shall be considered who offers a solution that does not conform in all material respects to the requirements contained in the original System Concept Document and subsequent system Development Life Cycle documentation.

NOTE: This policy **does not** supersede the capitalization policy #11-1011.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A

TULARE REGIONAL MEDICAL CENTER

INFORMATION SERVICES
SYSTEM CONCEPT DOCUMENT

This concept proposal is being submitted on behalf of:
<Enter Department Director name and department>

***REQUIRED STEPS**

***Situation:**
<What is the problem?>

***Background**
<What are the circumstances leading up to this situation?>

***Assessment:**
<What are your findings?>

***Recommendation:**
<What is the proposed solution?>

***Ongoing Support:**
<Please enter data here that will help Information Services staff understand the expected support requirements of the proposed system.> i.e., a separate server, hosted system, additional hardware.>

***Compliance and Security:**
<Please provide any compliance or security issues that this project will address.>

***Proposed Vendor:**
<Please provide appropriate contact information for any vendors you have already identified as a potential partner.>

***Estimated Costs:**
<Please provide all estimated costs associated with this project, if known.>

Additional Considerations:
<Enter other information you deem appropriate.>

Page 1 of 3

TULARE REGIONAL MEDICAL CENTER
INFORMATION SERVICES
SYSYTEM CONCEPT DOCUMENT
SIGNATURE PAGE

Project Name: _____

Requisitioned by:

_____ _____
Department Director Signature Date

Feasibility Reviewed by:

_____ _____
Director of Information Services Signature Date

Referred to Information Management Planning Council: Yes No

Additional comments:

_____
_____
_____
_____
_____
_____

COUNCIL REVIEW:

_____ _____
Committee Chairperson Signature Date

Referred to Security and Compliance: Yes No

Additional Comments:

_____
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_____
_____
_____
_____

Page 2 of 3

~~TULARE REGIONAL MEDICAL CENTER~~

~~INFORMATION SERVICES~~
~~SYSYTEM CONCEPT DOCUMENT~~
~~SIGNATURE PAGE~~

~~Security and Compliance Reviewed by:~~

_____ _____
~~Corporate Compliance/Quality Officer~~ ~~Date~~

~~Referred to Senior Management: Yes No~~

~~Additional Comments:~~

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~~Senior Management Reviewed by:~~

_____ _____
~~Senior Management Officer Signature~~ ~~Date~~

~~APPROVED: Yes No~~

~~Additional Comments:~~

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~~Page 3 of 3~~

1. Tulare Regional Medical Center (TRMC) has formed the Information Technology Operations Council (ITOC) and Information Technology Executive Council (ITEC) as an IT governance body to make strategic and tactical information technology Change Management (CM) decisions. The ITOC/ITEC will assist in maintaining software compatibility, hardware compatibility, reduction of system duplication, security of networks, and efficiency and effectiveness in information technology / management.
2. The ITOC is comprised cross functional leadership including Department Managers, Chief Compliance/Quality Officer, Financial, Clinical Division, and Information Services.
3. The ITEC will be comprised of personnel Executive leadership, Department Managers, Chief Compliance/Quality Officer, Financial and Clinical Division, and other hospital personnel including Information Services staff.
4. Each Department Manager shall complete and forward a new system request to the Director / CIO of Information Services. The Director / CIO of Information Services will handle the request internally or delegate the request to the ITOC.
5. ITOC assesses the proposal and then either approves, denies, or refers to the requesting department questions or recommendations. The primary tools for this approval shall be the Change Management (CM) program.
6. The ISO and/or Chief Compliance/Quality Officer shall review the request to ensure the system is compliant with hospital policy, local, state and federal law.
7. **Change Management (CM) Program**
    a. Change Management – TRMC uses a documented change management and control process for system and configuration changes.
    b. TRMC's CM program is chartered to maintain software compatibility, hardware compatibility, reduction of system duplication, maintain the security of the network, and efficiency of information systems residing on TRMC's network.
    c. When a new system, application, or 3rd party vendor is being considered for implementation onto TRMC's network, or is undergoing a major upgrade, a Change Management Committee consisting of the CIO, ISO, Business Manager, and ad hock members with vested interests in the system/application, will establish minimal security requirements, assess compatibility with TRMC's network, and minimize duplication of other systems/applications previously deployed on the network.
    d. TRMC Workforce Members are required to receive approval through the CM Committee before entering into any contractual obligation impacting TRMC information systems, applications, or data handling. This includes business partners.
8. **Establishing Security Requirements for New Applications:**
    a. Business Managers/Business Application Owners must identify security requirements as early as possible during the application development and/or acquisition process and document those requirements for review by the CM Committee.
    b. Applicable security requirements will be identified as part of any project proposal and will be submitted to potential vendors/suppliers for attestation they meet these requirements before contracts are finalized.
    c. Business managers/Business Application Owners are accountable for ensuring security requirements are aligned with regulatory and compliance

requirements. They must identify and including any relevant legal, regulatory, or contractual requirements before implementation. For example, HIPAA Security Rule, Card Holder Data, Sarbanes-Oxley (SoX), SB-1386, etc.

9. **Secure Application Development Methodology:**
   a. TRMC will use processes that have been formally adopted, documented, and communicated for developing or acquiring applications and migrating them into production in a secure manner.
10. **Security Risk Assessment:**
   a. Security risk assessments are a mandatory part of the Project Development Life Cycle of a system, application, or vendor relationship.
11. **Application Design:**
   a. Business managers/Business Application Owners are accountable for ensuring and documenting that applications are designed to meet documented security requirements as determined by the risk assessment phase.
12. **Testing:**
   a. TRMC application testing is conducted in a computing environment separate from the production environment.
   b. TRMC application testing will not use actual production data. Data must be deidentified such that it will not contaminate production data.
   c. Business managers/Business Application Owners are accountable for testing the security controls of the system before the application is used in a production environment and must sign off on the results.
   d. Business managers/Business Application Owners are accountable for documentation of test scenarios, scripts, results, and any remediation activities performed to correct discovered defects or other problems.
13. **Implementation**
   a. Application Security Requirements: When installing or activating an application, Business managers/Business Application Owners are accountable for taking steps to avoid disrupting operations or exposing data to loss or damage or unauthorized disclosure through use of a controlled change methodology.
   b. Business managers/Business Application Owners are accountable for ensuring post- implementation reviews of new applications to affirm successful functioning of security controls.
14. **Operational Security Support.**
   a. Continuing Maintenance –Business managers/Business Application Owners are accountable for the regular review of the application and recommending and implementing appropriate modifications based upon changes to business or legal/regulatory requirements or technologies (e.g., discontinuation of support for a system component).
   b. Periodic Reassessment and Certification – Business managers/Business Application Owners are accountable for conducting and documenting periodic reassessments of application security technical controls, during the application's lifecycle, to evaluate their effectiveness and to plan for remediation of any identified deficiencies. The frequency of reassessment will be based upon the risk level of the application and applicable compliance requirements.

Note –The provisions of this policy are mandatory for business managers and TRMC-IT when applications process or store cardholder data (CHD). No exceptions will be given.

Descriptive Name: ~~Information Management Planning Council – Support of Information~~Information Security Policy- Change Management and Governance

Descriptive Type: ~~New~~ Revised Policy~~y~~

Attachments: None

Author: ~~Kenny Allen~~Dan Sedano

Typist: ~~Julie Gresham~~Dan Sedano

Creation Date: 04/09/09

Revision Date: 3/9/18

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
Board of Directors	~~04/22/09~~	

Effective Date: ~~04/23/09~~

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE MANUAL

TO: All Employees

FROM: Administration

SUBJECT: Information ServicesSecurity Policy – Virtual Private Network Security Policy Mobile Computing and Telenetworking

I. AUDIENCE:

The HIPAA Security policies affect all covered health care components that may be designated by Tulare Local Health Care District at anytime, to include Tulare Local Health Care District's partner/ subsidiaries but only to the extent that each component performs activities that would make such component a business associate of Tulare Local Health Care District. Such component would include any third party outsourced functions including billing, transcription, Information Technology Services, Insurance Department, Internal Audit, Office, Legal Counsel, Press Office/Public Affairs, Public Safety. These policies affect all Tulare Local Health Care District's workforce members in covered components.

II. PURPOSE:

The purpose of this policy is to implement security measures sufficient to reduce the risks and vulnerabilities of Tulare Local Health Care District's Virtual Private Network (VPN) infrastructure to a reasonable and appropriate level. Also, this policy is to provide guidelines for Remote Access IPSec or L2TP VPN connections to the organizational network.

III. SCOPE:

This policy applies to all Tulare Local Health Care District employees, contractors, consultants, temporaries, and other workers including all personnel affiliated with third parties utilizing VPN's to access the Tulare Local Health Care District network. This policy applies to implementations of VPN that are directed through an IPSec Concentrator.

IV. POLICY:

A. Approved Tulare Local Health Care District employees and authorized third parties (customers, vendors, etc.) may utilize the benefits of a VPN connection, which

are a "user managed" service. This means that the user is responsible for selecting an Internet Service Provider (ISP), coordinating installation, installing any required software, and paying associated fees. Further details may be found in the *Remote Access Policy, #11-6012.*

B. Additionally:

1. It is the responsibility of employees with VPN privileges to ensure that unauthorized users are not allowed access to Tulare Local Health Care District internal networks.

2. VPN use is to be controlled using either a one-time password authentication such as a token device or a public/private key system with a strong pass phrase.

3. When actively connected to the corporate network, VPN's will force all traffic to and from the PC over the VPN tunnel: all other traffic will be dropped.

4. VPN gateways will be set up and managed by Tulare Local Health Care District Information Services department.

5. All computers connected to Tulare Local Health Care District internal networks via VPN or any other technology must use one of the following approved AntiVirus software:

a. Symantec – Norton 360 (most current version); Norton Internet Security (most current version); Norton AntiVirus (most current version).

b. BitDefender – Total Security (most current version); Internet Security (most current version); AntiVirus (most current version).

c. McAfee – Total Protection (most current version); VirusScan Plus (most current version); Internet Security (most current version)

d. Computer Associates – CA Internet Security Suite Plus (most current version); CA Anti-Virus Plus (most current version); CA Anti-Virus (most current version).

e. ESET – Smart Security (most current version); NOD32 AntiVirus (most current version).

6. VPN users will be automatically disconnected from Tulare Local Health Care District's network after thirty minutes of inactivity. The

user must then logon again to reconnect to the network. Pings or other artificial network processes are not to be used to keep the connection open.

7. Users of computers that are not Tulare Local Health Care District-owned equipment must configure the equipment to comply with Tulare Local Health Care District's VPN Network Security policy.

8. Only Tulare Local Health Care District, Information Services department approved VPN clients may be used.

9. By using VPN technology with personal equipment, users must understand that their machines are a de facto extension of Tulare Local Health Care District's network, and as such are subject to the same rules and regulations that apply to Tulare Local Health Care District-owned equipment.

a. Hardware Requirements:

1. Operating System: Windows XP 32-bit or 64-bit; Windows Vista 32-bit or 64-bit
2. Windows 7 32-bit

10. The following VPN client's are the only approved and tested VPN client to be used. Approved users are responsible for the installation of the VPN software.

a. Cisco VPN v.3.6 or v.4.0 for Windows XP 32-bit

b. Cisco VPN Client v.5.0 for Windows Vista 32-bit

c. NCP Secure Entry Client for Windows XP & Vista 64-bit – http://www.ncp-e.com/en/downloads/software.html

V. Enforcement

Any employee found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

VI. DEFINITIONS:

IPSec Concentrator A device in which VPN connections are authenticated.

VII. REFERENCE:

International Standards Organization (ISO/IEC 17799:2000(E))

~~NIST standards~~

~~Questions concerning any aspect of this policy/guideline should be referred to Administration.~~

~~This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.~~

PURPOSE:

The purpose of this policy is to implement security measures sufficient to reduce the risks and vulnerabilities of Tulare Local Health Care District's Network infrastructure to a reasonable and appropriate remote connections into the organizational network.

Tulare Regional Medical Center (TRMC) - Owned Mobile and Stationary Computing Systems / Devices and Electronic Media.

Workforce members must have a documented business need, approved by their supervisor, before applying for remote access to TRMC networks and computing systems/devices. The process for applying for and receiving approval to connect remotely to TRMC networks, computing systems/devices and electronic media is supported by TRMC-IT and managed by Human Resources.

To protect TRMC mobile and stationary computing systems/devices and electronic media from access by unauthorized persons and from loss, theft, damage, and destruction:

Workforce members must use the access control protection features (e.g., passwords, PIN, encryption) of stationary and mobile computing systems/devices containing TRMC information, to prevent access by unauthorized persons at all times.

TRMC and its workforce members must use reasonable physical controls to protect TRMC stationary and mobile computing systems/devices. This includes never leaving TRMC mobile assets unattended in parked vehicles and other physical controls such as locking cables.

TRMC workforce members approved to store TRMC data on a TRMC-owned mobile or stationary computing systems/devices or electronic media must comply with the TRMC Information Security Policy, *Secure Electronic Storage of Member/Patient Data.*

Non-TRMC-Owned Mobile and Stationary Computing Systems/Devices and Electronic Media.

TRMC workforce members must protect non-TRMC-owned mobile and stationary computing systems/devices and electronic media containing TRMC business related information from access by unauthorized persons, loss, theft, damage, and destruction.

TRMC workforce members must use the appropriate access control protection features (e.g., passwords, user IDs, and encryption) on non-TRMC owned

mobile and stationary computing systems/devices containing TRMC business information to prevent access by unauthorized persons. (See the TRMC Information Security Policy, *User Access Management*).

- TRMC workforce members must use appropriate physical and technical safeguards to protect non-TRMC-owned mobile and stationary computing systems/devices and electronic media if it is used to access or store TRMC business information.
- TRMC workforce members who are approved in writing, to store PHI on non-TRMC owned mobile and stationary computing systems/devices or electronic media must comply with the TRMC Information Security Policy, *Secure Electronic Storage of Member/Patient Data*.

Mobile Computing and Teleworking

- TRMC workforce members must comply with applicable TRMC-IT requirements in configuring operating system and application security for non-TRMC-owned mobile and stationary computing systems/devices, including, as applicable, installation of patches (software to mitigate known vulnerabilities).
- TRMC workforce members must install, activate, and maintain malicious code detection/remediation software on non-TRMC-owned mobile and stationary computing systems/ devices used for TRMC business. (See the TRMC Information Security Policy, *Protection Against Malicious Software and Viruses.)*

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Author: ~~Kenny Allen~~Dan Sedano

Typist: ~~Julie Gresham~~Dan Sedano

Creation Date: 08/13/09

Revision Date: 3/9/18

Previous Dist. Date: ~~None~~

Committee Review:	Approval Date:	Comments:
IT Steering Committee	~~08/18/0~~9	~~Approval by E-mail~~
Board of Directors	~~12/16/09~~	

Effective Date: ~~12/17/09~~

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

DELETE

TO: All Employees

FROM: Administration

SUBJECT: Information Services – Remote Access Policy

I. AUDIENCE:

The HIPAA Security policies affect all covered health care components that may be designated by Tulare Local Health Care District at anytime, to include Tulare Local Health Care District's partner/ subsidiaries but only to the extent that each component performs activities that would make such component a business associate of Tulare Local Health Care District. Such component would include any third party outsourced functions including billing, transcription, Information Technology Services, Insurance Department, Internal Audit, Office, Legal Counsel, Press Office/Public Affairs, Public Safety. These policies affect all Tulare Local Health Care District's workforce members in covered components.

II. PURPOSE:

The purpose of this policy is to define standards for connecting to Tulare Local Health Care District's network from any host. These standards are designed to minimize the potential exposure to Tulare Local Health Care District from damages which may result from unauthorized use of Tulare Local Health Care District resources. Damages include the loss of sensitive or company confidential data, intellectual property, damage to public image, damage to critical Tulare Local Health Care District internal systems, etc.

III. SCOPE:

A. This policy applies to all Tulare Local Health Care District employees, contractors, vendors and agents with a Tulare Local Health Care District-owned or personally-owned computer or workstation used to connect to the Tulare Local Health Care District network. This policy applies to remote access connections used to do work on behalf of Tulare Local Health Care District, including reading or sending email and viewing intranet web resources.

B. Remote access implementations that are covered by this policy include, but are not limited to, dial-in modems, frame relay, ISDN, DSL, VPN, SSH, and cable modems, etc.

IV. POLICY:

A. General:

1. It is the responsibility of Tulare Local Health Care District employees, contractors, vendors and agents with remote access privileges to Tulare Local Health Care District's corporate network to ensure that their remote access connection is given the same consideration as the user's on-site connection to Tulare Local Health Care District.

2. The Tulare Local Health Care District employee is responsible to ensure that family members do not violate any Tulare Local Health Care District policies, do not perform illegal activities, and do not use the access for outside business interests. The Tulare Local Health Care District employee bears responsibility for the consequences should the access be misused.

B. Requirements:

1. Secure remote access must be strictly controlled. Control will be enforced via one-time password authentication or public/private keys with strong pass-phrases. For information on creating a strong pass-phrase see the Password Policy #11-6013.

2. At no time should any Tulare Local Health Care District employee provide their login or email password to anyone, not even family members.

3. Tulare Local Health Care District employees and contractors with remote access privileges must ensure that their Tulare Local Health Care District-owned or personal computer or workstation, which is remotely connected to Tulare Local Health Care District's corporate network, is not connected to any other network at the same time, with the exception of personal networks that are under the complete control of the user.

4. Tulare Local Health Care District employees and contractors with remote access privileges to Tulare Local Health Care District's corporate network must not use non-Tulare Local Health Care District email accounts (i.e., Hotmail, Yahoo, AOL), or other external resources to conduct Tulare Local Health Care District business, thereby ensuring that official business is never confused with personal business.

5. All hosts that are connected to Tulare Local Health Care District's internal networks via remote access technologies must use one of the following approved AntiVirus software, this includes personal computers:

    a. AntiVirus software:

        i. Symantec – Norton 360 (most current version); Norton Internet Security (most current version); Norton AntiVirus (most current version).

        ii. McAfee – Total Protection (most current version); VirusScan Plus (most current version); Internet Security (most current version).

        iii. Computer Associates – CA Internet Security Suite Plus (most current version); CA Anti-Virus Plus (most current version); CA Anti-Virus (most current version).

        iv. BitDefender – Total Security (most current version); Internet Security (most current version); AntiVirus (most current version).

        v. ESET – Smart Security (most current version); NOD32 AntiVirus (most current version).

6. Virus signatures are to be updated at a minimum daily, hourly recommended.

7. Personal equipment that is used to connect to Tulare Local Health Care District's networks must meet the requirements of Tulare Local Health Care District-owned equipment for remote access.

8. The following VPN client's are the only approved and tested VPN client to be used. Approved users are responsible for the installation of the VPN software:

    a. Cisco VPN v.3.6 or v.4.0 for Windows XP 32-bit

    b. Cisco VPN Client v.5.0 for Windows Vista 32-bit

    c. NCP Secure Entry Client for Windows XP & Vista 64-bit – http://www.ncp-e.com/en/downloads/software.html.

9. Organizations or individuals who wish to implement non-standard Remote Access solutions to the Tulare Local Health Care District production network must obtain prior approval from Tulare Local Health Care District's Information Services department.

V. Enforcement:

Any employee found to have violated this policy may be subject to disciplinary action, up to and including termination of employment.

VI. DEFINITIONS:

Term	Definition
Cable Modem	Cable companies such as Comcast Broadband provide Internet access over Cable TV coaxial cable. A cable modem accepts this coaxial cable and can receive data from the Internet at over 1.5 Mbps. Cable is currently available only in certain communities.
CHAP	Challenge Handshake Authentication Protocol is an authentication method that uses a one-way hashing function. Data Link Connection Identifier (DLCI) is a unique number assigned to a Permanent Virtual Circuit (PVC) end point in a frame relay network. DLCI identifies a particular PVC endpoint within a user's access channel in a frame relay network, and has local significance only to that channel.
Dial-in Modem	A peripheral device that connects computers to each other for sending communications via the telephone lines. The modem modulates the digital data of computers into analog signals to send over the telephone lines, then demodulates back into digital signals to be read by the computer on the other end; thus the name "modem" for modulator /demodulator.
Dual Homing	Having concurrent connectivity to more than one network from a computer or network device. Examples include: Being logged into the Corporate network via a local Ethernet connection, and dialing into AOL or other Internet service provider (ISP). Being on a Tulare Local Health Care District-provided Remote Access home network, and connecting to another network, such as a spouse's remote access. Configuring an ISDN router to dial into Tulare Local Health Care District and an ISP, depending on packet destination.

DSL	Digital Subscriber Line (DSL) is a form of high-speed Internet access competing with cable modems. DSL works over standard phone lines and supports data speeds of over 2 Mbps downstream (to the user) and slower speeds upstream (to the Internet).
Frame Relay	A method of communication that incrementally can go from the speed of an ISDN to the speed of a T1 line. Frame Relay has a flat-rate billing charge instead of a per time usage. Frame Relay connects via the telephone company's network.
ISDN	There are two flavors of Integrated Services Digital Network or ISDN: BRI and PRI. BRI is used for home office/remote access. BRI has two "Bearer" channels at 64kbit (aggregate 128kb) and 1 D channel for signaling info.
Remote Access	Any access to Tulare Local Health Care District's corporate network through a non-Tulare Local Health Care District controlled network, device, or medium. Split-tunneling Simultaneous direct access to a non-Tulare Local Health Care District network (such as the Internet, or a home network) from a remote device (PC, PDA, WAP phone, etc.) while connected into Tulare Local Health Care District's corporate network via a VPN tunnel. VPN Virtual Private Network (VPN) is a method for accessing a remote network via "tunneling" through the Internet.

VI. REFERENCE:

International Standards Organization (ISO/IEC 17799:2000(E))

NIST standards

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Information Services - Remote Access Policy

Descriptive Type: New Policy

Document Number: 11-6012

Attachments: None

Author: Kenny Allen

Typist: Julie Gresham

Creation Date: 08/13/09

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
IT Steering Committee	06/18/09	Approval by E-mail
Board of Directors	12/16/09	

Effective Date: 12/17/09

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT ~~HOSPITAL~~
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : All Hospital Departments

FROM : Administration

SUBJECT: Emotional and Attitudinal Support

Tulare Local Healthcare District ~~Hospital~~ (TLHCD~~DH~~) has a continuing concern and commitment to provide needed spiritual, emotional, and attitudinal support to patients and their families, and to hospital personnel.

In an effort to provide the comprehensive components of care, the following support service arrangements have been made:

SPIRITUAL NEEDS	**Referrals to t**he Tulare Ministerial Association or the minister of choice. (See Policy #10-1092 TLHCD Chaplaincy Program -Partners In Healing)
EMOTIONAL SUPPORT/ ATTITUDINAL SUPPORT	A Social Worker is available to assist patients, families and hospital personnel with emotional and attitudinal support including evaluation, counseling, and referral services.

Because of the complexity of these areas of need, any or all of these services may overlap.

TLHCD~~H~~ maintains directories of community resources of health and social services for Tulare County in the Social Service Office and the Case Management Office. The directories contain a comprehensive listing of specialized support agencies (such as alcoholism, drug abuse and senior citizen services, etc.).

The TLHCD~~H~~ Medical Social Service Workers and Case Managers are designated to coordinate the facilitation of these support services to those in need of them.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~10/23/08~~

Approved:

Medical Executive Comm.: ~~10/15/08~~

(12) Nursing Services
General:
Emotional & Attitudinal Support
12-1002

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

Board of Directors: ~~10/22/08~~

Descriptive Name: Emotional & Attitudinal Support

Descriptive Type: Revised ~~1/16/18~~

Document Number: 12-1002

Attachments: None

Author: ~~Ruben Rojas~~/Andrea Carrasco/Ena Menezes

Typist: ~~Hillary Keith~~Carol Bradford

Creation Date: 11/31/05

Revision Date: 01/16/18

Prev. Dist. Date: 12/29/05

Committee Review and Approval:	Approval Date:	Comments:
UR Committee	N/A~~09/25/08~~	
MEC	N/A~~10/15/08~~	
Board of Directors	~~10/22/08~~	

Effective Date: ~~10/23/08~~ ~~1/16/18~~ 10/23/08

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Interfacility Patient Transfers to Skilled Nursing or Intermediate Care Facilities

I. POLICY:

A. In an effort to facilitate a timely and smooth transfer of patients from Tulare Regional Medical Center to Skilled Nursing or Intermediate Care Facilities, the following procedures are necessary to be completed prior to the transfer:

B. Families will be referred to all local convalescent facilities where available beds have been identified. The patient and/or family will be asked for their preference for Skilled Nursing Facility (SNF) or Intermediate Care facilities for placement. Families will be encouraged to tour the facilities to help them make an informed decision. The family will be instructed to make all financial arrangements with the transfer facility. Every effort will be made to comply with patient/family wishes when there is a preferred placement.

C. Transfer orders should be written as early as possible.

D. The Case Manager or designee shall contact the Skilled Nursing or Intermediate Care Facility with the patient information and check bed availability. If the Case Manager is not available, the Nursing Supervisor shall assist the patient's nurse to coordinate the transfer.

E. The following information is required, if applicable by the nursing home and may be faxed to the facility before the transfer is facilitated:

1. Interfacility transfer form signed by the attending physician.

2. Patient face sheet (Demographics).

3. History and Physical.

4. Physician's Progress Notes.

5. Current Labs and Cultures.

6. Medical Imaging Reports.

7. A complete list of the patient's medications.

8 Physical Therapy Notes

9. Other information as requested by the Skilled Nursing or Intermediate Care Facility.

F. Transportation to the receiving facility can be provided by Ambulance Services, Wheelchair Service, or Family, which ever is determined to be the most appropriate, and medically necessary.

G. No patient shall be transferred to a Skilling Nursing or Intermediate Care Facility without an appointed and verified attending physician. If the patient is to be transferred to the care of a different physician, the attending physician is responsible for contacting the receiving physician to communicate all necessary information for continuing care.

II. References:

Department of Public Health Services, 1262.5(d) (1) Health & Safety Code 1262

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

Descriptive Name:	Interfacility Patient Transfers to Skilled Nursing or Intermediate Care Facilities
Descriptive Type:	Revised
Document Number:	12-1020
Attachments:	None
Author:	Shawn Stewart/Charlene Dawson
Typist:	Melissa Arend
Creation Date:	12/29/05
Revision Date:	~~10/08/15~~ 01/16/18
Prev. Dist. Date:	01/27/11

Committee Review and Approval:	Approval Date:	Comments:
UR Committee	~~10/26/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date:	~~02/25/16~~ ~~1/16/18~~ 02/25/16
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff

FROM: Administration

SUBJECT: Bioethics Committee

Definition – bioethics: a discipline dealing with the ethical implications of biological research and applications especially in medicine

The growth of medical technology and the rapid expansion of knowledge have generated unprecedented opportunities and challenges in delivering healthcare. However, this growth in knowledge and medical capability has also created complex ethical issues for physicians, nurses, administrators, patients and their families. Consequently, the Tulare Local Health Care District Bioethics Committee was created to help clarify these issues when they arise.

Tulare Local Health Care District strives to provide not only the highest quality medical care, but to do so in a humane and compassionate fashion. Many factors, other than strictly medical ones, impinge on the delivery of care including to the terminally ill – psychological, social, legal, religious and economic. Current medical interventions permit life preserving unprecedented dilemmas in patient care.

The hospital's Bioethics Committee may help develop and review guidelines for cases in which ethical issues are raised; procedures for reviewing such cases; and institutional policies regarding care and treatment of such patients. The Committee may retrospectively and concurrently review cases; consult with concerned parties to facilitate communication and aid conflict resolution; and help educate TLHD staff on bioethical matters.

Effective Date: ~~11/25/03~~ (12) Clinical Services
General:
Approved: Bioethics Committee
12-1026

Bioethics Committee: ~~10/21/03~~

Medical Executive Comm: ~~11/12/03~~

Board of Directors: ~~11/24/03~~

The committee does not serve, however, as a review board of professional ethics, as a substitute for legal or judicial review, nor as a decision making body in ethical dilemmas.

Meetings

The Bioethics Committee is composed of at least two medical Staff members, a representative from administration and nursing, a member of the clergy and an outside community member, whenever possible.

The Bioethics Committee will meet as often as necessary, at the call of its chairperson.

For more information on the Tulare Local Health Care District Bioethics Committee, please contact the Bioethics Chairman and/or Administration.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Bioethics Committee

Descriptive Type: Revised

Document Number: 12-1026

Attachments: None

Author:

Typist: Debra Campbell

Creation Date: 10/20/03

Prev. Dist. Date: 12/27/01

Revised Date: 4/24/18

Committee Review and Approval	Approval Date:	Comments:
Bioethics Committee	N/A	Date change only
MEC	N/A	Date change only
Board of Directors		

Effective Date: 11/25/03

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – (Administration)Debra Campbell

Comments:

Date Completed:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff

FROM: Administration

SUBJECT: Private (Non-Coroner) Autopsy Protocol for Tulare Local Healthcare District

I. **PURPOSE OF THE AUTOPSY**

A. Provide diagnostic service to the clinical staff.

B. Provide the referring TRMC attending clinician with documented autopsy findings.

C. A teaching tool for clinical and Medical Staff.

II. **PROCEDURE FOR ORDERING A PRIVATE (NON-CORONER) AUTOPSY**

The private autopsy is a formal consultation provided to members of the Tulare Regional Medical Center Medical Staff. The autopsy is performed by a Tulare Regional Medical Center staff pathologist. It is at the discretion of the Pathologist to determine payment if available.

When there has been a pronouncement of death and determination that the death is **NOT** a coroner's case (as detailed in TRMC policy manual memo: Patient Death and Physician Pronouncement), the physician shall obtain a signed consent for autopsy by the next of kin in duplicate. One copy of the consent form shall accompany the decedent to the county morgue facility where the autopsy will be performed. The other becomes a part of the permanent hospital record.

Special effort should be made to secure permission for autopsy in any of the following circumstances:

1. When death is not anticipated outcome;
2. When the cause of death is not known;
3. Situations where autopsy may help allay concerns of the family.
4. When death occurs following surgical procedure or invasive diagnostic procedure done during the same hospitalization.

5. When death occurs in patients who are participants in formal clinical trials;
6. All obstetrical and neonatal deaths.

It is the responsibility of the attending physician to contact the pathologist assigned to the case, discuss clinical aspects of the case, and arrange to be present at the autopsy if necessary.

III. **AUTOPSY PROTOCOL**

The autopsy protocol consists of a written description of gross and microscopic findings at autopsy with toxicological results if applicable. While the final format will vary slightly it will generally consists of concise narrative paragraphs arranged into organ systems. The face sheet will list all significant anatomic findings.

A preliminary anatomic diagnosis will be issued in writing within three (3) days of autopsy with completion of the final report by sixty (60) days. Rarely the final report will be delayed due to extenuating circumstances such as detailed toxicological examination or other special tissue procedures such as consultation, electron microscopy, or cytogenetic studies. Such special studies may be initiated by the pathologist or requested by the attending physician. The preliminary and final report will be part of the patient's permanent medical record.

Important processes and outcomes of the autopsy will be reviewed at the appropriate medical staff, multi-disciplinary committee for education purposes.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Private Autopsy Protocol for Tulare Local Healthcare District

Descriptive Type: Revised

Document Number: 12-1027

Attachments: None

Author: Sharon Fong and Gary A. Walter, M.D.

Typist: Melissa Arend

Creation Date: 05/25/06

Revision Date: ~~11/12/15~~ 01/17/18

Prev. Dist. Date: 08/25/11

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Medicine Comm	~~01/20/16~~	
MEC	~~02/10/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~ 02/25/16

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : Medical Staff, nursing Services, Emergency Services and medical Records

FROM : Administration

SUBJECT: Leaving Hospital against Medical Advice

PURPOSE:

To provide guidelines for when a patient or the patient's legal representative on behalf of the patient chooses to sign out "against medical advice" (referred to as "AMA"), acting against the advice of the patient's physician(s).

POLICY:

A competent adult has the right to leave the hospital against the medical advice of a treating physician, and the legal representative for an incompetent patient has the right to allow the incompetent patient to leave AMA. Patients desiring to leave without a physician's order for discharge will be asked to confer with the patient's physician(s) and if the patient or legal representative still decides to leave AMA, the patient or legal representative will be asked to sign the "Release for Leaving Hospital Against Medical Advice" form.

1. Definitions:

Competent: The ability to understand the nature and consequences of one's illness and the relative risks, benefits, and alternatives of treatment as well as make and communicate informed, deliberate choices about one's treatment.

Incompetent: The temporary or permanent inability to understand the nature and consequences of one's illness and the relative risks, benefits, and alternatives of treatment as well as to make and communicate informed deliberate choices concerning one's treatment, Incapacity can be caused by a disability or illness, the use of drugs or alcohol, a medical condition, the influence of medication, or other reasons.

Legal Representative: The person who is legally authorized to make decisions on behalf of an incompetent patient. See CHA Consent Manual on who may decide. (Alternative: cross reference the hospital policy on this issue.).

PROCEDURE:

1. Prevention:

A. Understand to the extent possible the reason for the patient's desire or decision

to leave AMA in order to address and attempt to resolve the patient's problem or concern.

B. Use all available resources to verbally intervene and prevent a patient from leaving AMA. This may include contacting social services, physician, nursing supervisor, or patient's family.

C. Contact the patient's physician so he or she can inform the patient of the benefits of staying and risks of leaving AMA in an effort to persuade the patient to reconsider his/her decision.

2. Assessing Decision-Making Capacity:

A. The patient's decision-making capacity shall be assessed and considered if the patient attempts to leave AMA. Critical factors include whether the patient is aware that his/her illness and/or death may result from treatment refusal and the rationale behind the patient's decision. Note: Determination of capacity may not be limited to and able to be validated by examination due to a patient's refusal.

B. If the physician believes that the patient is not competent, and the patient is at substantial risk for harming him/herself or others and the patient otherwise meets the requirements for a psychiatric hold, the physician should initiate the psychiatric involuntary commitment process to include completion of a petition and clinical certificate.

C. Patients may be considered competent if their decision is consistent with a personally held philosophy, theology, or value system.

3. Capacitated Adults

A. Intervention:

1. If the patient expresses a plan to leave AMA and the patient is competent, the patient has the right to leave and will be asked to confer first with his or her physician. If the patient refuses to talk with the physician, or after talking with the physician nevertheless still intends to leave AMA, the nursing staff should ask the patient to sign the "Release for Leaving Hospital Against Medical Advice" form. The patient's family is not allowed to either request on the patient's behalf or refuse a competent patient's request to leave AMA.

2. If a patient is missing or has eloped, nursing or other staff will immediately conduct a search of the unit and adjacent areas; if the patient is located, the patient will be escorted back to his/her room. If the patient refuses to return to his or her room, the patient will be asked to talk with his or her physician about being discharged AMA, and will be asked to complete the forms for an AMA discharge.

3. If the patient is not found on the unit, staff will contact security immediately and report a complete description of the patient's physical appearance as well as other critical information and will notify the patient's attending physician immediately.

    a. Security will immediately search the premises.

    b. If the patient is found on the premises, the patient will be asked to return to the hospital and/or to talk with his or her physician about being discharged AMA, and will be asked to complete the forms for an AMA discharge.

    c. If the patient is not found on the premises, security may notify the police that the patient has eloped when determined by the providers and/or administrators to be appropriate.

    d. Reporting to licensing (Department of Puplic Health Services) may be required, depending upon the circumstances.

B. Documentation:

    1. The patient's attending physician will be notified when a patient desires to leave without discharge orders or without physician approval or has eloped. Communication with the attending physician should be documented in the patient's medical record.

    2. The staff will ask the patient to sign the "Release for Leaving Hospital Against Medical Advice" form. If the patient signs the form, it will be placed in the medical record. If the patient refuses to sign the form, staff will document the refusal to sign the form as well as the date and time in the medical record.

    3. Staff interacting with the patient will document facts of the interaction in the medical record such as:

        a. The patient's capacity to make the decision to leave AMA;

b. The physician's discussion of potential risks of leaving which may include death;

c. The physician's and staff's ongoing concern for the patient (e.g., instructions to the patient that they may return at any time); and

d. Contact the police if necessary.

4. Completion of "Quality Review Report (QRR) Form"

a. A "Quality Review Report (QQR)" form should be completed and forwarded to the Department Director. These reports should include a description of the nature of the incident, physician involvement and any action taken.

b. Reports to licensing shall be completed when a patient is missing for more than four hours and there is an adverse event.

4. Incompetent Adults

A. Intervention:

1. If the patient is considered incompetent and therefore unable to make the decision to leave AMA, the refusal of care is invalid and the hospital (to include nursing, physicians and security) shall take appropriate actions to prevent the patient's departure. Consent for continued care shall be obtained from the patient's legal representative.

2. If the patient has eloped, nursing or other staff will contact security immediately and report a complete description of the patient's physical appearance as well as other critical information.

a. Security will immediately notify the police of the patient's elopement and search the building(s) and premises.

b. If the patient is located, security and other trained staff shall take appropriate actions to prevent the patient's departure and return the patient to the hospital.

c. If the patient is not located, the physician will be notified immediately.

B. Documentation

1. Staff interacting with the patient will document facts of the interaction in the medical record to include:

a. The patient's incapacity to make the decision to leave AMA;

b. If the patient eloped, all attempts to locate and return the patient to the hospital or ED; and

c. Contact with the police.

d. The family or Legal Guardian notified.

e. Notification of patient's desire to leave or elopement to the attending physician.

2. Completion of "Quality Review Report (QRR) Form"

a. A "Quality Review Report (QQR)" form should be completed and forwarded to the Department Director. These reports should include a description of the nature of the incident, physician involvement and any action taken.

b. All required reports to licensing (Department of Public Health Services) will be completed.

5. Minors

A. A request by a minor's legal representative (usually the parents) for discharge of the minor or to leave AMA shall be honored if the minor's physician has no reason to suspect child abuse/neglect by the legal representative. If the physician believes that the child should not be released to the legal representative, the child shall be held and protected until Child Protective Services (CPS) can investigate. CPS must be contacted immediately to direct the need to hold and/or release the minor patient.

6. Monitoring and Quality Improvement

A. Monitoring of the AMA process will occur through the reporting and analysis of events involving patients (capacitated and incapacitated) who request or attempt to leave against medical advice. Improvements and risk reduction strategies will be implemented as applicable and appropriate following data analysis.

POLICY/GUIDELINE MANUAL

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

POLICY/GUIDELINE MANUAL

LEAVING HOSPITAL AGAINST MEDICAL ADVICE

Date:_____ Time:_____

Name of Patient:_____

I understand that if I refuse offered services, I am doing so against the advice of the attending physician and the hospital administration. I acknowledge that I have been informed that my refusal may result in a worsening of my condition and pose a threat to my life, health and medical safety.

I release the attending physician and the hospital from all responsibility and any ill effects, which may result from this action.

I understand that I am welcome to return at any time.

_____
(Signature of patient or legally responsible person)

_____
(Relationship if other than patient)

_____
(Witness)

The patient or a legally responsible person was offered but refused to sign this form after explanation of his or her rights and the risks and benefits of the services offered.

Hospital representative who witnessed refusal to sign_____

Descriptive Name: Leaving Hospital against Medical Advice

Descriptive Type: Revised

Document Number: 12-1031

Attachments: 1 – Leaving Hospital Against Medical Advice

Author: Julie Gresham (Reviewed by Suzanne Van Hall – 11/06/07)

Typist: Julie Gresham

Creation Date: 11/05/07

Prev. Dist. Date: 8/29/02

Revision Date: 01/16/18

Committee Review and Approval:	Approval Date:	Comments:
Medicine	~~11/13/07~~	
Family Practice	~~11/29/07~~	
MEC	~~11/14/07~~	
Board of Directors	~~11/28/07~~	

Effective Date: ~~11/29/07~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Nursing Departments, Physical Therapy, and Human Resources

FROM: Administration

SUBJECT: Safe Patient Handling, Mobility, and Injury Prevention Program (Lift Team)

I. Policy

Tulare Regional Medical Center wants to ensure patients are mobilized and transferred in the safest manner while maintaining a safe work environment for employees. Mechanical lifting equipment and/or other approved patient handling aids should be used by direct patient care staff to prevent manual lifting and handling of patients. The lift team should be called when lifting or handling patients in emergent situations. The infrastructure includes patient lift equipment and/or approved patient handling aids, a lift team, employee training, and a "Culture of Safety" approach in the work environment.

II. Definitions:

A. Equipment Definitions:

1. Sara Lift: Patient transfer and transport device for patients who weigh less than 440 pounds and who cannot pull themselves up to a standing position but are able to bear weight.

2, Bed Scale: Patient transfer and transport device for patients who need to be weighed of 350 pounds.

3. Hoyer Lift: Patient lift for patients who weigh less than 700 pounds.

4. Hoover Jack: Patient lift and transfer for patients who weigh less than 800 pounds.

5. Hoover Mat: Patient transfer for patients unable to move who weigh less than 500 pounds.

6. Gait Belt: Patient lift from a sitting positing to assist in ambulation for patients who weigh less than 250 pounds.

7. Wheel Chair Scale: Weighs patients up to 1000 pounds.

B. Other Definitions:

1. **High Risk Patient Handling Tasks:** Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the task. These include, but are not limited to transferring tasks, lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, dressing patients, turning patients in bed, and tasks with long durations.

2. **High-risk Patient Care Areas**: Patient Care Units with a high proportion of dependent patients, requiring full assistance with patient handling tasks and activities of daily living. Designation is based on the dependency level of patients and the frequency with which patients are encouraged to be out of bed.

3. **Manual Lifting:** Lifting, transferring, repositioning, and moving patients using a caregiver's body strength without the use of lifting equipment/aids to reduce forces on the worker's musculoskeletal structure.

4. **Mechanical Patient Lifting Equipment:** Equipment used to lift, transfer, reposition, and move patients. Examples include lift and stand assist lifts, and mechanized lateral transfer aids.

5. **Patient Handling Aids:** Equipment used to assist in the lift or transfer process. Examples include gait belts, stand assist aids, sliding boards, and surface friction-reducing devices (slide sheets).

6. **Culture of Safety:** Describes the collective attitude of employees taking shared responsibility for safety in a work environment and by doing so, providing a safe environment of care for themselves as well as patients.

III. Training:

1. All clinical staff will complete training prior to performing minimal lift/transfer techniques and mechanical equipment/handling aids upon hire to the organization.

2. A refresher training for current and new equipment and lift/transfer techniques will be performed annually. Validation of competency for safe patient handling will be completed.

3. Handling techniques and mobilizations will be performed annually. The Education department will maintain training records.

IV. Patient Handling and Movement Requirements:

1. Use mechanical lifting devices and other approved patient handling aids for patient handling, transfers, and movement tasks.

2. For high risk patients or in a medical emergency utilize the Lift team for assistance.

3. Employees who have been trained may utilize mechanical lift equipment and/or approved handling aids to care for their own health and safety, as well as that of their co-workers and their patients during patient movement or transfer activities by following this policy. Non-compliance by any staff member without using the mechanical lift equipment and/or handling aids, or demonstrating a reasonable effort to obtain such equipment, or calling the lift team could be subject to disciplinary action.

V. Mechanical Lifting Devices and Other Equipment/Aids:

1. Mechanical lifting devices and other equipment/aids will be accessible to staff.

2. Mechanical lifting devices and other equipment/aids will be maintained regularly and kept in proper working order.
3. Mechanical lifting devices and other equipment/aids shall be stored conveniently and safely.

VI. Back Injury Prevention Program:

1. The Back Injury Prevention Program includes the following key program elements:

   A. Ergonomic Workplace Assessments.

   B. Use of lifting equipment and devices.

   C. Patient Assessment Criteria and Care Planning for Safe Patient Handling and Movement (See Initial Patient Assessment and Reassessment Nursing Policy).

   D. Employee Incident Review Process

2. Reporting of injuries/Incidents:

   A. All incidents/injuries resulting from patient handling and movement must be reported to the department Director or designee.

   B. Tulare Regional Medical Center shall maintain Incident Reports and supplemental injury statistics as required.

VII. Roles and Responsibilities

1. TRMC Management/Directors shall:

   A. Support & enforce the implementation of this policy.

   B. Ensure mechanical lifting devices and other equipment/aids are available, maintained regularly, in proper working order, and stored conveniently and safely.

   C. Ensure employees complete initial and annual training, and re-training as required if employees show a lack of understanding.

   D. Non-compliance with safe patient handling and movement or equipment use could result in employee disciplinary action.

   E. Conduct accident/incident investigations.

IX. Employees shall:

1. Comply with all parameters of this policy.

2. Use proper techniques, mechanical lifting devices, other approved equipment/aids, or utilize the Lift team during performance of high-risk patient handling tasks.

3. Notify the department Director or designee of any injury sustained while performing patient handling tasks. Complete incident report.

4. Notify your immediate supervisor of need for re-training in use of mechanical lifting devices, other equipment/aids and lifting/moving techniques.

5. Complete a maintenance work order for any mechanical lifting devices in need of repair.

6. Support a “Culture of Safety” within the facility.

X. Lift Team shall:

1. Each clinical area will assign one staff member per shift to the lift team.

2. The lift team will respond when paged overhead by the operator “Lift team” to designated area.

3. Members will utilize mechanical lifting devices and other approved equipment to ensure the safety of high risk patient handling or transfers.

4. In an emergency situation the team members will take direction from the RN who will assess and communicate the most appropriate patient handling for the safety of the patient and the staff.

XI Maintenance/BioMedical Department shall:

1. Maintain mechanical lifting devices in proper working order.

2. Perform routine maintenance of the equipment.

XIII. Reference:

1. HR 2480.IH (2013-2014) 113th Congress, Nurse and Health Care Worker Protection Act of 2013.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately

Descriptive Name:	Safe Patient Handling, Mobility, and Injury Prevention Program (Lift Team)
Descriptive Type:	Revised
Document Number:	12-1032
Attachments:	None
Author:	Angie Graziano
Typist:	~~Julie Gresham~~
Creation Date:	11/21/13
Prev. Dist. Date:	05/28/09

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee	~~02/06/14~~	
MEC	~~02/12/14~~	
Board of Directors	~~02/26/14~~	

Effective Date:	~~02/27/14~~ 1/17/18
Forward To:	Policy Binders (5) and post to Intranet site
Disposition:	Copy and Distribution — Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Clinical Services, Medical Staff

FROM: Administration

SUBJECT: "Hand-off" Communication

I. POLICY:

1. "Hand-off" communication will take place whenever there is a change in the patient's caregiver. Caregivers include all clinical staff and physicians.

2. "Hand-off" communication shall include:

   A. Accurate patient information regarding care, treatment and services.

   B. Current patient condition.

   C. Recent or anticipated changes in the patient's condition.

3. All information will be presented in a clear, concise manner.

4. Staff shall be allotted the time to "hand-off" patient communication and to ask and answer questions with minimal interruption. This will facilitate accurate and complete communication, and minimize the possibility that information would fail to be conveyed or would be forgotten.

5. Examples of patient care transitions where "hand-off" communication will take place:

   A. At the change of shift between nursing staff.

   B. When a nurse leaves the unit for a period of time, such as lunch or to accompany a patient to another unit or diagnostic department.

   C. When a physician transfers complete responsibility for a patient.

   D. When physicians and nurses are transferring patients to another level of care.

Effective Date: ~~12/29/05~~

(12) Clinical Services
General:
"Hand-off" Communication
12-1035

APPROVED:

Medical Executive Comm.: ~~12/14/05~~
Board of Directors: ~~12/28/05~~

E. Anesthesiologist's report to the PACU RN and/or to the unit's licensed nurse.

F. Critical Clinical Laboratory and Medical Imaging results ("critical test results") sent/called to the licensed nurse and/or physician's office. Critical test results include "stat" tests or studies, "panic value" results, and other diagnostic test results requiring urgent response.

G. Verbal or telephone orders.

II. PROCEDURE:

1. Caregivers shall find a quiet area to give report (hand-off communications) to ensure accurate, clear and concise information is given with a minimum of interruptions.

2. Caregivers will give each other the opportunity to ask questions, answer questions and read-back or repeat-back information, as needed. For verbal or telephone orders or telephonic reporting of critical test results, whenever possible the receiver of the order or tests result should write down or enter into the computer the complete order or test result, then read it back and receive confirmation from the person giving the order or test result.

3. Information provided during hand-off communications transferring patient care responsibility will include at a minimum:

   a. Patient's name and location

   b. Patient's physician

   c. Date of admission

   d. Diagnosis

   e. Summary of the patient's current physical condition including

      1. Applicable medication information

      2. IV's present: saline lock and/or IV solution, rate of infusion

      3. Most recent vital signs

      4. Input and output, when applicable

5. Oxygen, ventilator settings when applicable

6. Wound dressings, drains, etc.

7. Emotional status

8. Pain assessment and management

f. Allergies

g. Recent or anticipated changes in the patient's condition

h. Pertinent past medical and surgical history

i. The patient's resuscitation status

j. Results of recent Clinical Laboratory and diagnostic tests

k. Patient problem list

l. Treatment, care and services that need to be completed (to do list)

m. Any other information which is important to the patient's care.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: "Hand-off" Communication

Descriptive Type: ~~New~~Revised

Document Number: 12-1035

Attachments: None

Author: Julie Gresham~~Julie Gresham~~

Typist: Carol Bradford~~Julie Gresham~~

Creation Date: 11/16/05

Revision Date: 01/22/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Legal Counsel	~~12/13/05~~	
Services Committees		Information only
MEC	~~12/14/05~~	
Board of Directors	~~12/28/05~~	

Effective Date: ~~12/29/05~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration
Board approved copy to Legal Counsel

Comments: Policy address JCAHO NPSG – 2E "Hand-off" Communication

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Prevention of Tubing/Catheter Misconnections

I. BACKGROUND:

1. Tubing and catheter misconnections errors occur with significant frequency as reported by the FDA, the Institute for Safe Medication Practices (ISMP), United States Pharmacopeia (USP), ECRI and the Joint Commission.

2. The types of tubes and catheters involved in misconnection errors include:

   - Central intravenous catheters
   - Peripheral IVs
   - Nasogastric feeding tubes
   - Percutaneous enteric feeding tubes
   - Peritoneal dialysis catheters
   - Tracheostomy cuff inflation tubes
   - Automatic blood pressure cuff insufflation tubes

II. POLICY:

1. Tulare Regional Medical Center will establish, as a part of its Patient Safety Program, a plan that recognizes tubing and catheter misconnections, risk assessment of new tubing/catheters and equipment, acceptance testing of new tubing/catheters and staff, patient and family education.
2. Intravenous, epidural, or enteral feeding connections that would fit into a connection port other than the type it was intended for, unless an emergency or urgent situation exists and the prohibition impairs the ability to provide health care shall be prohibited. (SB 158)

Effective Date: ~~05/28/09~~	(12)	Clinical Services: General: Prevention of Tubing/Catheter Misconnections 12-1036
APPROVED: Medical Executive Comm.: ~~05/13/09~~ Board of Directors: ~~05/27/09~~		

3. Tulare Regional Medical Center, when possible, shall not purchase non-intravenous medical equipment that has connectors that can join with a female luer IV line connector.

4. Before new tubing/catheters are placed into use in this facility, a risk assessment will be performed by the Products Evaluation Committee, along with acceptance testing (performance, safety and usability testing), to identify the potential for misconnections.

    A. If a risk is identified, the appropriate preventive measures will be instituted.

5. Clinical and non-clinical staff shall receive education regarding tubing/catheter misconnections. Education will be provided at orientation and in-services.

6. Non-clinical staff shall be instructed to seek the help of a clinician if tubing or equipment needs to be disconnected and/or connected, if this does not fall under their scope of practice, i.e., technicians, nursing assistants, students.

7. Patients and families shall be educated to seek help from clinical staff to connect or disconnect infusions or equipment.

III. PROCEDURE:

1. Clinical Staff shall:

    A. At a minimum, check all tubes, catheters and connectors from the patient to the point of origin at the beginning of the shift and after the patient is moved.

    B. Trace a tube or catheter from the patient to the point of origin before connecting or disconnecting an infusion or equipment.

2. The correct connector sequence shall be followed when connecting tubing and components of medical equipment.

3. Organize tubes and catheters that have different purposes in different directions.

    A. All IV lines will be organized toward the patient's head

    B. Enteric lines will be organized toward the patient's feet

    C. This shall be the standard throughout the hospital

4. Label high-risk catheters, such as epidurals, intrathecal catheters and arterial lines.

5. **NOT USE** a standard luer syringe for administration of oral medications or enteric feedings.

6. Perform a line reconciliation process upon a patient's arrival to a new unit or service. The clinician shall check all connections and trace all tubes and catheters to their sources. This shall be a component of hand-off communication.

8. Always follow manufacturers' instructions and precautions regarding the use of medical equipment and supplies.

9. **NOT** modify IV or feeding devices. Doing so may compromise the safety features built into the devices

10. Remind patient and families to ask for help if equipment needs to be connected or disconnected.

IV. REFERENCES:

1. Joint Commission Sentinel Event Alert, Issue 36, April 3, 2006

2. *Luer Lock Misconnections can be Deadly*, December 2005, FDA Patient Safety News, Show #46, ~~http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=46~~

3. *Luer Lock Misconnects Can be Deadly*, Melissa Eakle, RN, MBA, MSN, Beverly Albrecht Gallauresi, RN, BS, MPH and Audrey Morrison, RN, Nursing 2005, September.

4. Senate Bill (SB) 158 (Florez, Chapter 294, Statues of 2008) (Health and Safety Code Sections 1279.6 and 1279.7) Effective January 1, 2011

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Prevention of Tubing/Catheter Misconnections

Descriptive Type: Revised

Document Number: 12-1036

Attachments: None

Author: Julie Gresham~~Julie Gresham~~

Typist: Carol Bradford~~Julie Gresham~~

Creation Date: 06/30/06

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Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee	~~04/17/09~~	
MEC	~~05/13/09~~	
Board of Directors	~~05/27/09~~	

Effective Date: 05/28/09

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments: Joint Commission Sentinel Alert #36

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Clinical Nursing Department

FROM: Administration

SUBJECT: Management of Patients in Corridor Locations

Purpose:
To establish a safe care experience for patients who must be temporarily managed in a corridor location.

Scope & Applicability:
This is an organization-wide policy. It applies to all care settings.

Policy:
1. Patients will be placed in corridor locations as a temporary measure only. The routine use of corridors to hold patients or to provide care is prohibited. Providing ongoing care (over a period of several hours) in a corridor location is forbidden. Should a patient need to be held in a corridor location, the following shall apply:

   A. Placement of a patient in a corridor location is considered a last resort and should be deployed only after designated bed locations have been filled.

   B. Patients will not be housed in fire egress corridors except as a temporizing measure – meaning that they will be immediately (within 30 minutes) moved into an interior corridor or bed. No furnishing, equipment, or supplies will be housed in fire egress corridors to treat such patients. Equipment and supplies must be brought to the patient and then returned or discarded when care is completed.

   C. Patients who are critically ill or who require hemodynamic / ventilatory monitoring will not be placed in corridor locations.

   D. Patients should be removed from corridor locations and placed in designated beds as soon as they become available.

   E. The corridor location will be clearly delineated and known to staff providing care, treatment, or service in the area.

   F. Each patient in the corridor location will have their specific location clearly

delineated (e.g. “Corridor Bed 1”, “Corridor Bed 2”, etc). The patient shall be placed on a functional gurney with side rails up at all times.

G. Patients in a corridor location will have access to a nurse call system (portable is permitted) and a method to assure their privacy when care is rendered. If such a call system is not available, then staff must be in continuous attendance of the patient.

H. No complex invasive or non-invasive procedures shall be performed on patients in corridor locations.

I. Qualified staff will be immediately available to monitor patient care needs in the corridor location.

J. A comparable level of care will be provided to patients placed in corridor locations. Sufficient equipment, supplies, and services will be available and provided to the same extent as if the patient was placed in a designated bed

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Management of Patients in Corridor Locations

Descriptive Type: ~~New~~Revsied Policy

Document Number: 12-1037

Attachments: None

Author: Julie Gresham~~Julie Gresham~~

Typist: Carol Bradford~~Julie Gresham~~

Creation Date: 03/11/08

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Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~04/09/08~~	
Board of Directors	~~04/23/08~~	

Effective Date: ~~4/24/08~~

Forward To Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments: Plan of Correction for Joint Commission Periodic Review Report completed in January 2008 - Meets Joint Commission Standard LD.3.15

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Assessing and Managing Patients at Risk for Suicide

PURPOSE:

To conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide and to assure that their immediate safety needs are met in the most appropriate care setting within the scope of services provided by the organization.

SCOPE AND APPLICABILITY:

This policy applies to patients being treated for emotional or behavioral disorders in either inpatient or outpatient setting. ~~.~~Based on the scope of services provided, potential treatment for emotional and behavioral disorders outside of a behavioral health setting within a general acute care hospital is limited to:

1. Inpatient Care

2. The Emergency Department

DEFINITIONS:

For the purposes of this policy, the term *"treatment for emotional or behavioral disorder"* is defined as a patient seeking care, treatment, or service for primary diagnosis or complaint of an emotional or behavioral disorder, or requiring acute medical care and intervention due to the impact of a behavior or emotional disorder. This may include, but not be limited to;

1. Patients seeking treatment for symptom manifestation of a psychiatric condition such as acute or chronic depression, bi-polar, schizophrenia, psychosis, etc.

Effective Date: ~~03/29/12~~ (12) Clinical Services General: Assessing and Managing Patients at Risk for Suicide 12-1038

APPROVED:

Medical Executive Comm.: ~~03/14/12~~

Board Of Directors: ~~03/28/12~~

2. Patients seen for medical evaluation and treatment following attempted suicide or harm to self.

3. A patient who verbalizes or otherwise indicates a desire or intent to self harm while under the organization's care. For the purposes of this policy, the term *"lethality"* is defined as the likelihood of a patient making an actual attempt to commit suicide or cause significant self-harm.

POLICY:

1. Initial Assessment of a Patient's Risk of Suicide:

   A. Applicable patients will be assessed for the risk of suicide utilizing the SAD PERSONS Scale ~~an~~ assessment tool (~~See Attachment A~~Located in the Electronic Medical Record) that includes identification of specific factors and features that may increase or decrease the risk of suicide.

   B. The risk assessment will be completed within the time frames established for each patient care unit and Emergency Department's Scope of Service assessment guidelines.

   C. Social Services shall be notified of the Patient's admission.

2. Reassessment of a Patient's Risk of Suicide:

   A. Patients who were identified as being at risk for suicide as a result of the initial assessment will receive, when appropriate, a reassessment to determine if there is an increase or decrease in their risk of suicide. The following are only guidelines for frequency of reassessment. It is expected that the frequency of reassessment will be ultimately guided by the care needs of the individual patient.

      1. Inpatient Units – Every shift and as needed per the patient's condition.

      2. Emergency Department – None required unless length of stay is over 24 hours, then daily or as needed per the patient's condition.

3. Who May Perform a Suicide Risk Assessment / Reassessment?

   A. The following individuals are authorized to perform the suicide risk assessment by virtue of their education, training, and/or experience:

      1. Physicians

      2. Clinical Social Workers

B. The following individuals are authorized to perform a suicide risk assessment upon completion of a designated training module provided by the organization or upon providing evidence of comparable training and/or education.

1. Registered Nurses

4. Meeting a Patient's Immediate Safety Needs:

A. Patients who have been identified as a suicide risk will have a plan of care established to meet their immediate safety needs, and assure that care is rendered in the most appropriate setting possible. While general guidelines have been developed in the SAD PERSONS Scale (~~See Attachment A~~), the scope, nature, and frequency of interventions necessary to assure the safety of the patient will depend on the individual patient's assessed level of risk and lethality.

5. Appropriate Care Setting:

A. Patients presenting to the Emergency Department shall be evaluated to determine the need for a psychiatric evaluation. If the patient is deemed in need of psychiatric treatment, the following criteria shall be assessed:

1. All Medical complaints shall be stabilized. If the patient requires ongoing acute medical care, then the patient shall be admitted to an inpatient care unit consistent with the guidelines established in the SAD PERSONS Scale. ~~attachment A.~~

2. If the patient requires a higher level of care that this facility cannot provide, the patient will be transferred to an appropriate facility.

3. Patient's that have been "medically cleared", shall be assessed by Mental Health Services, prior to discharge or transfer to a psychiatric unit.

B. Patients admitted to an inpatient care unit for ongoing acute medical care, shall be assessed as described in the SAD PERSONS Scale ~~attachment A~~. Once the ongoing acute medical condition has been "medically cleared", Mental Health Services shall be contacted to evaluate the patient, prior to discharge or transfer to a psychiatric unit.

6. Providing Information to the Patient / Family on Crisis Intervention:

A. Applicable patients and (when appropriate) their families, regardless of risk level, will be provided with information on how to access assistance in a crisis~~ie~~s situation. There is no defined time frame in which this information

must be provided, but it should be provided before discharge or transfer from organization's care.

B. Crisis Intervention Agencies may be contacted at:

- Mental Health – Tulare County
  - ~~559-733-6877~~
- National Crisis Hotline
  - ~~1-800-SUICIDE (1-800-784-2433)~~
- National Suicide Prevention Lifeline
  - ~~1-800-273-TALK (1-800-273-8255~~
  - ~~TTY – 1-800-799-4889~~
- Youth Crisis Hotline
  - ~~1-800-448-4663~~

7. Training:

A. All RN's shall complete the "Assessing and Managing the Suicidal Patient Staff Training Module" and post test or show evidence of equivalent education, prior to managing patient's at Risk for Suicide. All documentation will be stored in the Education Department and forwarded to the HR department upon completion, to be placed in the employees file.

B. All new hire RN's shall complete the education module and post test or show evidence of equivalent education, within their orientation period and prior to managing patient's at Risk for Suicide. All documentation will be stored in the Education Department and forwarded to the HR department upon completion, to be placed in the employees file.

C. All CNA's, Telemetry Technicians and Emergency Technicians shall also be educated as to managing patient's at risk for suicide.

D. Other employees: Training for non-nursing employees shall be at the discretion of the department director.

References:

- American Psychiatric Association Practice Guidelines for the Assessment & Treatment of Patients with Suicidal Behavior – 2003
- "Screening for Suicide Risk", United States Preventive Services Task Force – 1999
- "Inpatient Suicides: -Recommendations for Preventions", Joint Commission, SE Alert #7
- Evaluation of suicidal patients : The SAD PERSONS scale – 1983 Patterson W., Dohn H et all Psychosomatics Vol 24 : No 4

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A

SAD PERSONS Scale Check all that apply and then total score			
RISK FACTOR	SCORE	RISK FACTOR	SCORE
☐ Sex - Male	1 point	☐ Separated, divorced, widowed, or death within past 12 months	1 point
☐ Age – less than 19 or greater than 45 years	1 point	☐ Organized plan, serious attempt	1 point
☐ Depression (Dx of depression, insominia, severe anxiety, agitation, panic disorders, and bipolar illness	1 point	☐ No social support (no spouse or family)	1 point
☐ Previous Attempt or psychiatric care within past 12 months	1 point	☐ Sickness (chronic, debilitating, cancer, epilepsy, MS)	1 point
☐ Rational thinking loss (psychosis, organic brain syndrome	1 point	☐ Excessive alcohol or drug use	1 point
☐ Ideation with Vague Plan	1 point	**TOTAL SCORE**	

☐ **Social Services Notified of Admission: By: _____ Date: _____**

Interventions Taken:

Low to Moderate Risk Score 0 - 4

- Precautions implemented :
  - Place patient in room closest to the nurse's station as possible.
  - Place patient in appropriate colored gown.
  - Place patient in a private room when possible.
  - Check patient's room, person and belongings for any possible hazardous items.
  - Remove belts, shoelaces, ties, suspenders, scarf's, sashes and bra's.
  - Remove any medications, razors, box cutters or pocket knifes, etc.
  - Food trays shall have plastic cups, plates, bowls, forks and spoons. No Glass. No silverware.
  - If patient wants to shave, staff member to assist patient.
  - Provide patient with a bell for calling for assistance. No call light.
  - Observe patient at least **hourly**.
  - Encourage to verbalize feelings.
  - Reassess patient as per hospital policy.
  - b

High Risk Score – 5 or greater

- 1:1 Observation with hospital staff at all times. If the staff member needs to leave the room, another staff member must replace them. **At no time, shall the patient be left alone, NOT even when family members are present.**
- Implement other applicable precautions under Low degree Lethality listed above.
- Place patient in appropriate colored gown.

~~Discharge education as per hospital policy.~~

Descriptive Name: Assessing and Managing Patients at Risk for Suicide

Descriptive Type: Revised Policy

Document Number: 12-1038

Attachments: Suicide Risk Assessment Tool

Author: Suicide Assessment Team / Pat Speers

Typist: ~~Pat Speers/Gillian Busch~~ Andrea Carrasco/Ena Menezes

Creation Date: 12/14/11

Revision Date 01/17/18

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee	~~02/10/12~~	
Emergency Medicine Comm.	~~02/14/12~~	
MEC	~~03/14/12~~	
Board of Directors	~~03/28/12~~	

Effective Date: ~~03/29/12~~ 03/29/12

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Case Management, Patient and Family Services and Medical Staff

FROM: Administration

SUBJECT: Displaced or Homeless Patient

I. POLICY:

A. Pursuant to Section 1262.4 of Health and Safety Code of the State of California "homeless patient" is here defined as any individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide~~d~~ temporary living accommodations or to be used as a sleeping accommodation for human beings. And, includes no hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, may cause the transfer of homeless patients from one county to another county for the purpose of receiving supportive services from a social service agency, health care service provider, or nonprofit social service provider within the other county, without prior notification to, and authorization from, the social service agency, health care service provider, or nonprofit social service provider.

B. Social Workers, SW Associates/Discharge Planners, or designee, who have contact with patients who may be displaced, transient, or homeless, are to offer these individuals appropriate resources in the community or county that will be able to meet their needs for shelter, food, and clothing.

C. The patient will not be discharged from the hospital unless arrangements for his or her minimal needs are coordinate with an appropriate human service agency in the community, or outside the county if an accepting agency agrees in receiving and meeting the needs of the patient.

D. If the patient is mentally competent and declines the services that have been arranged, or offered, to him or her, the patient will then be discharged as ordered by Primary Medical Physician [PMD], and patient will be asked to sign release of liability form.

II. PROCEDURE:

A. Social Workers, SW Associates, or designee, will accept all referrals from PMD's, Case Managers [CM], and Medical Staff who are requesting assistance on patients who meet criteria for being displaced, transient, and/or homeless.

B. SW, SW Associate, or designee will evaluate patient first hand to gain information on patient's living situation, support system, resources, and his or her plans after discharge from hospital. A reasonable and appropriate discharge plan will be developed by Social Workers/SW Associates, and effort will be made to solicit the patient's input and support of the discharge plan.

C. Interview and intervention of the patient needs will be documented and filed in patient's chart; and, PMD will be notified of patient contact and discharge plans of the patient prior to discharge.

D. If patient refuses to receive services offered to him due to the limitation of services, location of shelter, or other related concern. It is the patient's right to decline services as Patient's Rights dictate for all patients; and his or her decision on the matter will be respected. If necessary, at time of discharge order per PMD, patient will be asked to sign the Discharge Planning Placement Refusal form ~~(see attachment A)~~, and will then be discharged to self.

E. If patient agrees to discharge to shelter outside of County, SW, SW Associate, or Designee, shall:

1. Have prior contact with receiving agency.

2. Provide information of patient needs to receiving agency prior to discharge.

3. Assistance with transportation to receiving agency, if needed.

4. Any other arrangement, or appointments, as ordered by PMD.

III. Reference:

AB 2745

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

~~**ATTACHMENT A**~~

~~**TULARE REGIONAL MEDICAL CENTER**~~

~~**DISCHARGE PLANNING PLACEMENT REFUSAL FORM**~~

~~I, _____was provided assistance by the Hospital Social Worker/Discharge Specialist for the purpose of locating an appropriate form of shelter. I am presently homeless and I was explained that I would need to cooperate with their efforts in order to be placed in a Men's/Women's Shelter.~~

~~I do decline the referral for shelter for personal reasons; or, due to my limits as to where I would be willing to go. I understand that in so doing, I have limited my options for community assistance and support.~~

~~At this time, the only option left for me is to be released to myself, and resume my former living arrangements.~~

~~My signature below confirms my decision to decline this offer for placement in a shelter.~~

~~I hereby release Tulare Regional Medical Center of any liability and responsibility of my decision for placement in a Men's/Women's Shelter.~~

_____ _____
~~Patient Signature Date~~

_____ _____
~~Witness Date~~

Descriptive Name: Displaced or Homeless Patient

Descriptive Type: Revised Policy

Document Number: 12-1039

Author: ~~Shawn Stewart/~~Charlene Dawson /Andrea Carrasco/ Ena Menezes

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 10/23/08

Revision Date: ~~10/08/15~~ 01/17/18

Prev. Dist. Date: 01/27/11

Committee Review and Approval:	Approval Date:	Comments:
UR Committee	~~10/26/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~ 02/25/16

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Patient Care Documentation during a Code Brown

Each department will keep a supply of forms and/or documents currently used for patient care. During the CODE BROWN, all patient care will be documented on these forms and then entered into the EHR~~computer~~ once the CODE BROWN is resolved.

All Patient and eMAR documentation will take place on hand written forms and ~~-~~medication sheets, if electronic documentation becomes unavailable. Patient documentation and ~~A~~administered medications will be entered into the computer when the CODE BROWN is resolved within 24 hours from initial downtime.

As of October 17, 2016~~February 1, 2011~~ TRMC is utilizing Cerner as EHR for patient documentation and medication administration.~~on Code Brown pertaining to medication administration pending implementation of Medication Administration Check (MAK) application~~.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~12/08/11~~ (12) Clinical Services
General:
Patient Care Documentation during a Code Brown
12-1041

APPROVED:

Medical Executive Comm.: ~~11/09/11~~

Board Of Directors: ~~12/07/11~~

Descriptive Name: Patient Care Documentation during a Code Brown

Descriptive Type: Revised Policy

Document Number: 12-1041

Attachments: None

Author: Abby Adesanya and Ezequiel Gonzalez

Typist: Ezequiel Gonzalez/Gillian Busch

Creation Date: 10/27/11

Prev. Dist. Date: 03/26/09

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~11/09/11~~	
Board of Directors	~~12/07/11~~	

Effective Date: ~~12/08/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Fall Prevention Program

I. PURPOSE:

1. To reduce the risk of patient harm resulting from falls. Patient's can expect caregivers to be knowledgeable in the use of multiple interventions that minimize the patient's risk of falling.

II. POLICY:

1. The basis for a fall prevention program is to assess all patients receiving care in the hospital, clinics as well as other applicable outpatient area. Each applicable patient care area will complete the assessment tool and screening assessment upon admission to the facility.

2. **General Safety Precautions** (see Attachment A) are instituted on all patients, regardless if they have been identified as being at risk for falls or not.

3. Neonates and infants are by definition at risk for falls due to their developmental age. A fall risk assessment is not necessary in this population; however **General Safety Precautions** will be implemented.

4. Children 1 year and above, and all adults shall have a risk fall assessment.

5. No specific assessment / reassessment of fall risk are required of patients seen in ambulatory care settings. However, if a patient presents with obvious risk criteria such as an unsteady gait, use of assistive devices, or other obvious need, then staff will take appropriate action to assure their safety during the provision of care, treatment, and service.

6. In addition, the environment of care in ambulatory settings is assessed during hazard surveillance rounds (environmental tours) at least every six months. If

hazards are identified that may pose a fall risk to patients in these settings, a work order will be initiated to correct the identified risk.

III. DEFINITION OF A FALL:

1. A **fall** is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions.

2. An **assisted fall** is defined as assisted to the ground by another person, i.e. staff or family.

3. An **un-witnessed fall** occurs when a patient is found on the floor and neither the patient nor anyone else knows how he or she got there.

IV. DELEGATION OF AUTHORITY AND RESPONSIBILITY:

1. The Department Director responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with Director of Engineering to aid in fall prevention.

2. Registered Nurses as well as other qualified staff are responsible for implementation and oversight of the individualized patients fall prevention care.

V. PROCEDURE:

1. Fall Risk Reduction Strategies: The organization has implemented the following strategies to reduce both the likelihood and severity of patient falls:

   A. All Medical/Surgical adult and pediatric (1 year or older) in-patients shall be assessed using the EMR ~~or using the~~ Fall Risk Assessment ~~Tool (see Attachment B)~~.
   B. All Emergency Department patients will have a fall risk assessment completed via the EMR.
   C. All obstetrical patients shall have a fall assessment via the EMR clinical documentation program.
   D. Out-patients who are determined to be at high risk will have a Red Dot placed on their ID band and/or on their chart or other paperwork to identify them as high risk.
   E. Home Care will perform a home assessment and provide information for establishing a safe home environment.
   F. Each patient will receive an initial assessment upon admission, under the following circumstances but not limited to:
      1. Reassessment every shift.

2. Following any change in condition.
3. Any transfer from unit to another unit within the facility.
4. Following a fall.
5. Patient is visibly unsteady.

2. The **General Safety Precaution** interventions shall be in place for **low** risk patients with a score of 20 or less (Attachment A)

3. The **Environmental Safety Precaution** interventions shall be in place for **moderate** risk patients with a score of 21-44 (Attachment A)

4. The **Fall Risk Protocol** interventions shall be established for **high** risk patients with a score of 45 or greater (Attachment A)

5. Additionally, all patients shall be considered **high risk** for falls and have Fall Risk Protocol interventions in place for:
   a. Patient's within 12 hours of a Spinal or Epidural Anesthesia.
   b. Post delivery obstetrical patients, up to void for first time.
   c. Any post-op patient up for the first time.

VI. POST FALL PROCEDURES/MANAGEMENT:

1. There are two key elements of the post fall procedures/management:
   A. Initial post-fall assessment
   B. Documentation and follow-up

2. Initial Post Fall Assessment:
   A. First priority is to assess the patient for any obvious injuries and find out what happened. The information needed is:
      1. Date/time of fall.
      2. Patient's description of the fall (if possible):
         a. What was patient trying to accomplish at the time of the fall?
         b. Patient getting up to bathroom, walking in room or hallway
         c. Slipped and fell
         d. Tripped and fell (over clothing, cords, lines, equipment, etc.)

      3. Patient assessment:
         a. Injuries
         b. Neurological Assessment to include:
            1. Mental Status – responsiveness, orientation to person, place and time
            2. Eye Response and Pupil size and reaction
            3. Hand strength (grip) response

4. Upper and Lower extremity strength response
5. Neurological checks frequency:
   i. q15 min x 4, q30 min x 2, q1 hr. x 2, 24, 48 and 72 hours **or** as specified by the physician

c. Vital signs (temperature, pulse, respirations, blood pressure)
d. Comorbid conditions (i.e., dementia, heart disease, neuropathy, etc.)
e. Current medications (were all medications given, new medications, was a medication given twice? Will type of medication effect mobility?)
f. Last time Narcotic or Sleeper was given.
g. Fall Risk reassessment

4. Physician notified using SBAR format (recommend CT of the head).

5. Notify the family or guardian.

3. Documentation and Follow-up:

A. The patient's nurse shall document the fall in the medical record, including the patient's assessment, any injuries, interventions and additional safety precautions that were put into place post fall.

B. Document electronically and add to Nursing Plan of Care any interventions and treatment goals.

C. Communicate to all shifts that the patient has fallen and is at risk for falls.

4. Reporting Patient Falls

A. Any fall occurring while under TRMC care will be reported through the electronic ~~Verge~~ Incident Report ~~or the 'Fall Variance Report' (see Attachment C)~~

5. Reporting Potential Fall Hazards:

A. Staff shall immediately report any hazards that could cause a patient harm, i.e., broken or loose hand rails, loose floor tiles, torn carpet, broken patient assistive devices, patient bed, and bedside table.
B. Hazards should be removed immediately, if possible and a work order initiated. Maintenance and/or Nursing Supervisor should be contacted if there is an immediate threat which can not be removed. Consider

moving patient to another room if the hazard can not be immediately removed or repaired.

VII. EDUCATING THE PATIENT/FAMILY ON FALL RISK:

1. Initiate Fall Prevention Education for the at-risk patient and/or family:
   - A. The patient/family is informed of the patient's fall risk status, safety issues, mobility limitations and plan of care.
   - B. The patient/family is educated on fall prevention techniques.
   - C. Provide teaching material on fall prevention that is available to the patient/family.

VIII. EDUCATION AND COMPETENCY OF STAFF:

1. Education occurs upon hire as part of the facility Mandatory Quest General Orientation Training, nursing orientation training, and individual's department orientation.

2. Nursing education program addresses at least the following:

   - A. How to identify at risk patients.
   - B. How to communicate the risk level to the patient, family, and health care team members.
   - C. Electronic documentation and/or the Fall Risk Assessment Tool (Attachment B).
   - D. Use of fall precautions and interventions.
   - E. Patient transfer and ambulation.
   - F. Use of fall related preventive equipment.
   - G. Documentation of electronic ~~Verge~~ Incident Report ~~/ Fall Variance Report.~~

IX. COLLECTING AND ACTING UPON PATIENT FALL REPORTS (PI):

1. The organization has a mechanism to collect, aggregate, analyze, and act upon data surrounding patient falls.
2. Data can be collected in such a manner as to identify any patterns or trends.
3. Data is presented to (PIPS) Performance Improvement Patient Safety Committee with the authority to analyze and act upon findings.
4. Opportunities identified are acted upon.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A

General Safety Precautions (Low risk, 20 or less)

1. Orient patient and family to environment.
2. Beds will be in low position with brakes on unless treatment needs require otherwise. After procedures, the bed will be returned to the low position.
3. Side rails will be up X2 when patient is left unattended as a safety precaution. **Exception:** Certain critical patient care situations may require that side rail(s) be kept down to accommodate tubes, drains and/or equipment. As always, patient safety is of utmost importance and safety measures will be taken to ensure that the patient is secure.
4. Call light within reach, Patient demonstrate use of call light.
5. Bedside table, telephone, and other frequently used items will be kept within reach of the patient, as developmentally appropriate.
6. Sensory aids (eyeglasses, hearing aids, etc.) will be accessible to the patient.
7. Assistance will be provided, as appropriate, to the patient requiring assistive devices (walker, crutches, etc.)
8. Ambulating patients must wear shoes or non-slip slippers/footwear. Patients will be accompanied when ambulating for the first time or whenever their clinical status indicates that they are at risk for falling. This would include but not be limited to medication side effects, neurological impairment and/or developmental stage.
9. Keep environment clear of hazards.
10. Assist with elimination as needed.
11. Implement evaluation of medications that predispose patient to falls.
12. All patients 3years of age and under will be placed in cribs. If parents request otherwise, a written release must be obtained and it is with the understanding that they will have to continually attend the child.
13. Built in safety straps will be used with equipment such as swings or highchairs.
14. Children will be transported by crib or gurney and will have side rails up at all times.
15. Neonates and infants will be transported by bassinet at all times.
16. Educate patient and family regarding fall prevention strategies.

Environmental Safety Precautions (Moderate risk, 21-44)

1. All of the above General Safety Precautions plus:
2. Access for elimination needs frequently (every 2 hours). Consider placing a bedside commode near. Keep urinal/bedpan close per patient abilities and need.
3. Specific instructions to family and patient to call for assistance to be out of bed and/or rising slowly.
4. Slip resistant slippers provided for patient use.
5. Keep patient eyeglasses, assistive walking devices within easy reach.
6. When possible, give patient bed space nearest bathroom.
7. Provide physically safe environment (eliminate spills, clutter, electrical cords, unnecessary equipment).

8. Keep pathway to and from bathroom clear.
9. Equipment aids (walkers, canes, wheelchairs, crutches) should be assessed to be in proper working condition prior to use by patient.
10. Room night light or bathroom light on at all times.
11. Give “Safety Precautions” information sheet to patient/family.

Fall Risk Protocol (High risk, 45 or greater)

1. All of the above general precautions plus:
2. “Red Slippers” applied.
3. “Red Ruby Slipper” sign posted on patient’s door.
4. Red dot on ID band.
5. Use bed alarm, TABS alarm or Bed Check alarm PRN.
6. Observe the patient frequently, offer frequent bathroom visits, if applicable.
7. Keep the patient door open when visitors not present.
8. Room closest Nursing Station when possible.
9. Bed rail padding, as necessary.
10. Diversion measures.
11. Enlist family to remain with patient.
12. Provide sitter, as necessary.
13. Initiate Restraint policy if the above interventions are not sufficient to keep the patient safe.
14. Communicate at the beginning of every shift with oncoming staff (Hand-off Communication, SBAR).
15. Initiate an order for Fall Risk Protocol

ATTACHMENT B TULARE REGIONAL MEDICAL CENTER
FALL RISK ASSESSMENT TOOL

All Adult and Pediatric (1 year and above) patients will have a risk assessment performed every shift, and as the patient's condition changes or transfers to another unit.

VARIABLES		ATE AND TIME		TIME		ATE AND TIME		ATE AND TIME		ATE AND TIME	
Sedatives, Narcotics, Steroids											
Agitation / Confusion											
Urinary Incontinence / Frequency											
History of fall											
Medical condition - seizures, debilitating pain, osteoporosis, Metastatic CA, vertigo)											
Mobility – Unsteady Gait Ambulatory aid, crutches/cane/walker											
IV, Lines, Tubes, Foley											
65 years or older											
Physical Limitations, visual, auditory impairments, affecting mobility											
TOTAL SCORE											
STAFF SIGNATURE											

Fall Risk Score		
		General Safety Interventions
Moderate Risk		Implement Environmental Safety Interventions
High Risk	45 - higher	Implement Fall Risk Protocol Interventions

Patient Identification

ATTACHMENT B **TULARE REGIONAL MEDICAL CENTER**
OUT-PATIENT FALL RISK ASSESSMENT TOOL

Every Adult and Pediatric (1 yr and above) patient will have a risk for falls assessment performed with each admission/visit to the hospital.

		Initial Assessment Score	Date / Time	Post-Procedure Assessment Score	Date / Time
Sedatives, Narcotics, Steroids	25				
Agitation / Confusion	25				
Urinary Incontinence / Frequency	25				
History of fall	15				
Medical condition (seizures, debilitating pain, osteoporosis, Metastatic CA, vertigo	15				
Mobility – Unsteady Gait Ambulatory aid, crutches/cane/walker	10				
IV, Lines, Tubes, Foley	10				
65 years or older	10				
Physical Limitations, visual and/or auditory impairments, affecting mobility	10				
TOTAL SCORE					
SIGNATURE					

Fall Risk Score		
Low Risk	0 - 20	General Safety Interventions
Moderate Risk	21 - 44	Implement Environmental Safety Interventions
High Risk	45 - higher	Implement Fall Risk Protocol Interventions

Patient Identification

~~ATTACHMENT C~~

~~TULARE REGIONAL MEDICAL CENTER CONFIDENTIAL - FALL VARIANCE REPORT~~

~~DATE: TIME OF EVENT: DEPARTMENT:~~

LOCATION OF FALL (Bathroom, beside bed, hallway, etc.):

HISTORY OF FALLS: ☐ YES ☐ NO

PATIENT IDENTIFIED AS FALL RISK: ☐ YES ☐ NO

FALL WITNESSED: ☐ YES ☐ NO IF YES, BY WHOM:

OBSERVATION STATUS AT TIME OF FALL: ☐ q 2 HOURS ☐ 1:1 ☐ RESTRAINED ☐ OTHER:

MEDICATED WITH NARCOTIC / SLEEPER WITHIN 4 HOURS? ☐ YES ☐ NO MED NAME:

MENTAL STATUS: ☐ ORIENTED X 3 ☐ CONFUSED ☐ OTHER:

FALL: ☐ FROM BED ☐ FROM CHAIR ☐ WHILE WALKING ☐ OTHER:

POTENTIAL CAUSE:

- ☐ Sudden change in position
- ☐ Confusion
- ☐ Dizziness
- ☐ Unsteady Gait
- ☐ Incontinence
- ☐ Visual Impairment
- ☐ Blind
- ☐ Orthostatic Hypotension
- ☐ Hypertension
- ☐ Sedation
- ☐ Medication (specify): _____
- ☐ Wet floor (specify substance): _____
- ☐ Trip Hazard (specify): _____
- ☐ Assisted device (specify): _____

INJURY: ☐ NONE ☐ ECCHYMOSIS ☐ ABRASIONS ☐ HEMATOMA ☐ LACERATIONS ☐ FRACTURES

☐ LOSS OF CONSCIOUSNESS, HOW LONG: ☐ OTHER:

AREA OF INJURY: ☐ HEAD ☐ EYE ☐ CHIN ☐ BUTTOCKS ☐ HIP ☐ ARM ☐ LEG ☐ OTHER:

SEVERITY: ☐ NO INJURY

☐ MINOR INJURY (Required administration of minor first aid (i.e. band-aid, sutures, steri-strips, ice pack)

☐ MAJOR INJURY (Required Medical intervention (i.e. fracture repair, surgery)

☐ DEATH

ADDITIONAL COMMENTS: _____

IMMEDIATE ACTION TAKEN: ☐ NO ACTION REQUIRED ☐ X-RAY ORDERED ☐ CT OF HEAD ORDERED

☐ FIRST AID INITIATED ☐ RISK FOR FALLS REASSESSED ☐ 1:1 ☐ FAMILY AT BEDSIDE

☐ RESTRAINTS APPLIED ☐ ASSISTED DEVICES PROVIDED (Bedside commode, walker, etc)

☐ PATIENT MOVED CLOSER TO NURSES STATION ☐ PATIENT/FAMILY EDUCATION ☐ OTHER:

TIME PHYSICIAN NOTIFIED: TIME FAMILY NOTIFIED:

FORM COMPLETED BY: DATE: TIME:

REVIEWED BY DEPARTMENT DIRECTOR: DATE: TIME:

SEND COMPLETED REPORT TO THE QUALTIY DEPARTMENT - DO NOT PLACE IN MEDICAL RECORD

Descriptive Name: Fall Prevention Program

Descriptive Type: Revised

Document Number: 12-1043

Attachments: Attachment A Safety Precautions
Attachment B Fall Risk Assessment Tool
~~Attachment C Fall Variance Report~~

Author: Angie Graziano/Andrea Carrasco/Ena Menezes

Typist: Carol Bradford~~/Melissa Arend~~

Creation Date: 03/29/12

Revision Date: ~~02/03/17~~ 01/17/18

Previous Dist. Date: 11/20/14

Committee Review:	Approval Date:	Comments:
MEC	~~02/08/17~~	
Board of Directors	~~02/22/17~~	

Effective Date: ~~02/23/17~~ 02/23/17

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Patient Assessment / Interdisciplinary Plan of Care

POLICY:

A patient assessment is completed on every patient on admission by a Registered Nurse to identify age specific nursing care needs, educational needs and discharge needs. The admission assessment is the basis for developing the interdisciplinary Patient Plan of Care, which includes Standards of Care, Individualized Needs, Education and Discharge Plans. Reassessment and revisions to the Plan of Care are completed as indicated based on patient need and unit-specific standard (see individual unit specific Scope of Service for detailed assessment/reassessment information). All disciplines involved in care of a patient collaborate to develop the patient's plan of care.

GUIDELINES FOR ADMISSION AND REASSESSMENT PROCESS:

1. The Registered Nurse is responsible for completing the admission assessment record within the times established in their specific departmental Scope of Service, but no greater than 24 hours after the patient's admission.

2. The health and history information as well as required screening will be completed by the appropriate discipline at the time of the patient's admission.

2. The Registered Nurse is responsible for obtaining physician orders when necessary after arrival on the unit. The admission agreement and consent forms must be signed.

4. Patients that are transferred from one patient care unit to another including those who have had a surgical procedure will have a complete physical assessment completed and revised plan of care developed by the RN receiving the patient.

GUIDELINES FOR PATIENT PLAN OF CARE:

Effective Date: ~~09/27/12~~	(12)	Clinical Services General: Patient Assessment / Interdisciplinary Plan of Care 12-1044
APPROVED:		
Medical Executive Comm.: ~~09/12/12~~		
Board Of Directors: ~~09/26/12~~		

1. The Registered Nurse oversees the development of the plan of care, utilizing an interdisciplinary approach. Other departments/services are to develop specific goals and plans of care appropriate to needs of patient and family and document involvement is encouraged, and as much as the patient desires, in the development of the plan of care.

2. The Standards of Care are guidelines for patient care, and focus on predetermined care the patient can expect to receive. The Nursing Standards of Care are general, unit specific, and disease or treatment specific. All patients receive the General Standard of Patient Care, Unit, population served, disease or treatment specific based on patient diagnosis/need.

3. The hospital provides the patient with care, treatment and services according to his/her individualized plan of care. The plan is determined utilizing patient assessment information and focuses on patient needs for this hospitalization and will be updated as the patient's condition changes. The Plan of Care will be ~~prioritized using numbers 1, 2, 3, etc. and~~ documented in the electronic record.

4. The interdisciplinary care notes will be maintained in the ~~IPER section of the~~ Electronic medical record.

5. The Education Plan is developed after assessment. Documentation occurs ~~on IPER and or~~ in the electronic medical record during the hospital stay as needs are identified.

GUIDELINES FOR INTERDISCIPLINARY CARE NOTES:

1. Every discipline involved in the care of the patient will chart the following in the care notes:

   A. Date and time plan initiated.

   B. Individualized plan of action.

   C. Patient goals and outcomes.

   D. Identify discharge needs.

   E. Identify education needs and chart in the Electronic Medical Record. ~~on IPER.~~

   F. Date and time plan is revised, completed or discontinued.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient Assessment / Interdisciplinary Plan of Care

Descriptive Type: Revised Policy

Document Number: 12-1044

Attachments: None

Author: Angie Graziano/Andrea Carrasco/Ena Menezes

Typist: ~~Angie Graziano~~Andrea Carrasco

Creation Date: 08/27/12

Revision Date: 01/17/18

Prev. Dist. Date: 03/26/09

Committee Review and Approval:	Approval Date:	Comments:
Family Medicine Service	~~08/30/12~~	~~Approved by Virtual Vote 8-30-12 also presented to 9-13-12 Committee~~
Medicine Service	~~08/30/12~~	~~Approved by Virtual Vote 8-30-12 also presented to 10-16-12 Committee~~
MEC	~~09/12/12~~	
Board of Directors	~~09/26/12~~	

Effective Date: ~~09/27/12~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Determination of Brain Death

I. PURPOSE**:**

To provide information to medical staff regarding the medical and legal implications for determination of brain death.

II. POLICY:

A. The legal process for the determination of brain death is described in California Health & Safety Codes 7180, 7181, and 7182, and states: “An individual who has sustained either:

1. Irreversible cessation of circulatory and respiratory functions, or
2. Irreversible cessation of the entire brain, including the brain stem, is dead.

B. The law further states that “the determination of brain death must be made in accordance with accepted medical standards.” This statute requires that a second physician independently confirms the death and that neither physician be involved in decisions regarding transplantation of organs. (Related policy: See Anatomical Donations for Transplantation)

III. PROCEDURE:

A. The attending and consulting physician each shall document in the medical record the basis for their diagnosis of brain death, including irreversible cessation of circulatory and respiratory functions, or irreversible cessation of the entire brain, including the brain stem. The three cardinal findings in brain death are coma or unresponsiveness, absence of brain stem function, and apnea.

B. Confirmatory testing may be used at the discretion of the physicians and in accordance with accepted medical standards for the determination of brain death (i.e. EEG, Cerebral Blood Flow Study, Angiography, etc).

C. The patient's physician should explain brain death to the family members and significant others, and their understanding and agreement with the discontinuation of life support shall be obtained and documented in the medical record prior to the procedure being implemented.

D. The patient's family or next of kin shall be provided a reasonable brief period of accommodation. A "reasonably brief period" is an amount of time afforded to gather family or next of kin at the patient's bedside. The accommodation period is the time from when the patient is declared brain dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem through discontinuation of cardiopulmonary support of the patient. During this reasonable brief period of accommodation, the hospital will continue only previously ordered cardiopulmonary support. No other medical intervention is required.

E. The patient's legally recognized healthcare decision-maker, if any, or the patient's family or next of kin, if available, shall be provided with a written statement of this policy, upon request, but no later than shortly after the treatment physician has determined that the potential for brain death is imminent.

F. If the patient's legally recognized healthcare decision-maker, family, or next of kin voices any special religious or cultural practices and concerns of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.

G. Support services, including nursing, Social Services, and Chaplain Services, should be available and offered to the grieving family. The patient's comfort and dignity must be maintained at all times.

H. The patient shall be pronounced brain dead before discontinuing the respirator or ventilator.

I. The physicians who determine and independently confirm that brain death has occurred must document in the patient's medical record the basis for the diagnosis of brain death, including their clinical findings, the findings of any confirmatory tests that may have been performed, along with the date and time of the examination. (Refer to Checklist for Determination of Brain Death).

J. All brain deaths must be reported to the Organ Procurement Organization (OPO) Representative any time prior to, or within 60 minutes of the time the patient meets the criteria fro imminent death, and prior to any measures taken to decelerate care, for the evaluation of potential organ donation eligibility. (Related policy: See Anatomical Donations for Transplantation)

K. Disconnection from life support systems (Ventilator) may be performed by the patient's physician or his/her designee, RN or Respiratory Therapist.

L. All forms of medical intervention (e.g. intravenous lines, ventilator, etc.) should be removed after the patient's physician or his/her designee, RN or Respiratory Therapist has pronounced the patient dead, except in the following cases:

1. Coroner's case
2. Unusual humanitarian reason
3. Organ donation

REFERENCES:
California Health & Safety Codes, 7180, 7181, 7182
California Health & Safety Code Section 1254.4
Anatomical Donations for Transplantation policy

Please refer to "CHECKLIST FOR DETERMINATION OF BRAIN DEATH" attached to this policy.

Please refer to "AUTHORIZATION TO REMOVE LIFE SUPPORT"" attached to this policy.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Prior to initiation of assessment for brain death the patient should be assessed for normal findings in the following areas.

	Test 1	Test 2
1. Core Temperature	_____	_____
2. Endocrine Screen	_____	_____
3. Toxicology	_____	_____
4. Established unresponsiveness	_____	_____
5. Cerebral motor Response to pain	_____	_____
6. Removal of neuromuscular blockade	_____	_____
7. SBP greater then 90 mm Hg	_____	_____
8. PCO2 35mmHg to 45mmHg	_____	_____
9. Pupil size and reaction to light	_____	_____
10 Oculosephalic Reflex (dolls eyes)	_____	_____
11.Corneal Reflexes	_____	_____
12.Gag and cough reflex	_____	_____

Physician Signature Date/ Time_____

Physician Signature Date/ Time_____

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

AUTHORIZATION TO REMOVE LIFE SUPPORT

DATE:

We the family of _____ request and consent to discontinuance of life sustaining measures, including mechanical ventilation, for our _____.

We have consulted with his/her attending physicians and the Hospital Ethics Committee (if applicable) in this matter. We are aware her/his condition is irreversible and further treatment will be of no medical benefit to her/him. We are certain we are acting in _____'s (patient's name) best interests having weighed the potential benefit of further care against the potential burden of continuing life-sustaining measures that will have no benefit. We have concluded that it would not be consistent with our _____ (patient's relationship) wishes to continue with care that artificially continued her/his life.

We have been advised of the consequences of discontinuance of life support and have concluded that discontinuance of life sustaining measures remains consistent with _____ (patient's name) wishes, consistently expressed to us during her/his life.

We, the undersigned, are _____ family members and Tulare District Hospital and the physicians have sought informed consent from all of us. We are satisfied we have all the necessary medical information on which to make this decision. We are in agreement that this is the appropriate course of treatment.

DATE:

FAMILY MEMBERS:

_____ _____

_____ _____

_____ _____

ATTENDING MEDICAL PROVIDERS:

_____ _____

_____ _____

Descriptive Name: Determination of Brain Death

Descriptive Type: New

Document Number: 12-1049

Attachments: None

Author: Danita Brill

Typist: Julie Gresham

Creation Date: 11/03/10

Revised Date: 4/24/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~11/10/10~~N/A	Date change only
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Nursing Peer Review

I. POLICY:

A. The Nursing Peer Review Committee (NPRC) will delineate indicators for purposes of generic, random, and unit-specific review of patient charts. Additionally, circumstances, which may serve to initiate a review include but are not limited to unusual occurrences reports, peer concern, physician complaint, insurance inquiry, legal inquiry, medical record review/clinical pertinence, or patient/family complaint. The Nursing Peer Review Committee cannot take any action against a nurse being reviewed, but can only make recommendations regarding the quality of patient care rendered, qualification of the care provider, and merits of a complaint.

b. Generally, a peer is a member who holds the same licensure, i.e. RN to RN, Nurse Practitioner to Nurse Practitioner etc. Whenever indicated, and possible, a peer of the same unit will be used.

II. DEFINITIONS:

A. The Nursing Peer Review committee is responsible for monitoring the quality of nursing care offered to patients and provides a venue for identifying and recommending opportunities for improvement. Nursing peer review applies to all licensed hospital and contract nursing personnel delivering care to patients at Tulare Regional Medical Center. This policy excludes peer review conducted for level of practice advancement, annual performance review and ongoing peer review through established clinic/unit mechanisms. Peer review allows care providers the opportunity to be evaluated by persons knowledgeable of their job duties, scope of practice and responsibilities.

III. COMPOSITION:

A. Chair and Co-Chair

Effective Date: ~~08/25/11~~ (13) Clinical Services General: Nursing Peer Review 12-1050

APPROVED:

Medical Executive Comm.: ~~08/10/11~~

Board of Directors: ~~08/24/11~~

B. Selection:

The Chief Clinical Officer will appoint the Chair and/or Co-Chair positions.

C. Term of Office:

The term will be for a minimum of 1 year, maximum of 2 years.

D. Membership:

The leadership of each area will designate the members of the Nursing Peer Review Committee. Three-fourths of its membership must be registered nurses and to the extent feasible may include licensed vocational nurses.

E. Term:

The members will be designated for a term of two (2) years. This is a renewable term.

IV. PROCEDURE:

A. If appropriate and after initial screening by the Risk Management Department, a chairperson of the Nursing Peer Review team will be contacted to evaluate the issues identified in the case.

B. If appropriate and after 2nd level screening has taken place by a chairperson of the Nursing Peer Review Committee, the Risk Management Coordinator will provide relevant information in order to evaluate the care, treatment, documentation and nursing practice provided to the patient. The peer reviewer will be assigned to evaluate a case and determine if that case warrants notification of a nurse, follow up or practice/ process recommendations.

C. External Nursing Peer Review:

1. In cases that are specialty centric or involve potential conflict of interest, consideration will be given to using an external nursing peer reviewer.

2. If notification of the nurse is necessary, they shall have the right to understand the issue(s) involved and shall be notified by the Nursing Peer Review Chairperson assigned to screen the case. Recognizing that the nurse under review may have pertinent information that could affect the results of the review, it is encouraged that the individual respond to the Nursing Peer Review

Committee within 14 days of notification. The Chairperson shall communicate to the individual the outcome of the review within 7 days of case closure. The Chairperson may request a response from the individual following notification.

D. Timeframe for Completion:

1. First and second level screening will be accomplished within 28 days of identification of the event.

2. Nursing peer review will occur within 14 days of completing Second level screening.

3. Nursing Peer Review Committee will complete the entire review process within 60 days or up to 120 days for a more complex issue.

V. MEETINGS:

A. The committee shall meet monthly initially for approximately one year, then at least quarterly. It shall maintain a permanent record of its proceedings and actions and report said actions at least quarterly.

VI. CONFIDENTIALITY:

A. The committee proceeding is confidential and any communication made to the committee is privileged under California Business and Professions Code §805 and California Evidence Code §1157. A member or participant of the committee or its proceedings cannot disclose or be required to disclose a communication made to the committee or a record or proceeding of the committee. Information that is confidential is not subject to subpoena or discovery in any civil matter; it is not admissible as evidence in a judicial or administrative proceeding; and it may not be introduced into evidence in a nursing liability suit arising out of the provision of or a failure to provide nursing services. The nursing peer review process is an extension of the Medical Staff quality assurance processes.

VII. GROUND RULES;

A. Attendance:

1. Members are expected to attend a minimum of 75% of all meetings.

B. Agenda and meeting minutes will be provided.

C. Promptness:

1. Meetings will start and end promptly. It is the responsibility of late members to catch up on the subject matter from colleagues after the meeting.

D. Participation:

1. All members are expected to:

   a. Follow the policy.

   b. Fulfill the requirement of an office when appointed.

   c. Fulfill the requirements of a task or duty as assigned.

   d. Be prepared to discuss the issues on the agenda. Preparation includes reviewing meeting summaries, minutes, and/or clinical information in advance of each meeting.

   e. Be active listeners.

   f. Actively participate.

   g. Respect the opinions of others and feel free to challenge those opinions.

   h. Sign the Nursing Peer Review Confidentiality Agreement.

2. Courtesy/Interruptions/Distractions:

   a. Place digital beepers and cell phones on silent mode.

   b. Only one person may speak at a time when recognized by the chair.

   c. Avoid having side discussions.

   e. Members are expected to communicate concerns, interests and ideas openly and to make the reasons for their disagreements clear.

3. Decision-Making:

   a. Situation drives the decision-making process.

   b. If possible the committee will operate by consensus.

i. Members should not block or withhold consensus unless they have serious reservations with the approach or solution that is proposed. If members disagree with the approach or solution selected by the rest of the group, they should make every effort to offer an alternative satisfactory to all stakeholders.

ii. Members should remain at the table during deliberations to hear the full discussions to order to make informed judgments when decision-making occurs.

iii. Absence will be equivalent to not dissenting.

iv. If all efforts have been made to arrive at consensus, but it appears that the group will not be able to achieve it, the group may choose to vote in order to come to agreement (majority vote).

VIII. COMMUNICATION and REPORTING RELATIONSHIPS:

A. The committee will report quarterly to the hospital performance improvement committee on non–peer review activities (system improvements) and to clinical nursing division on peer review activities and action.

B. Other patient care operational issues identified will be communicated to management and/or the appropriate organizational committee as deemed appropriate.

C. The committee may request a response from the respective management personnel and/or organizational committee(s) following notifications.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Nursing Peer Review

Descriptive Type: ~~New~~Revision

Document Number: 12-1050

Attachments: None

Author: Peer Review Committee

Typist: Carol Bradford

Creation Date: 10/12/10

Revision Date: 01/18/18

Prev. Dist. Date: 08/25/11~~None~~

Approved by	Approval Date:	Comments
Nursing Peer Review Committee	~~01/03/11~~	
PI Committee	~~05/17/11~~	
MEC	~~08/10/11~~	
Board of Directors	~~08/24/11~~	

Effective Date: ~~08/25/11~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Medical Staff

SUBJECT: Medical Futility

I. PURPOSE

The purpose of this policy is to provide health care providers and medical staff of Tulare Regional Medical Center (TRMC) with the legal and ethical authority and guidelines to ensure patients receive appropriate treatment, and to avoid inappropriate intervention(s) when patients and/or surrogates demand interventions that clinicians consider medically ineffective or contrary to generally accepted health care standards. For purposes of this policy, diagnostic studies are considered interventions.

II. DEFINITION

A point at which any further interventions will not lead to a meaningful change in a patient's outcome.

III. POLICY

A. It is policy of TRMC that patients receive care that is both medically appropriate and within the generally accepted health care standards.

B. The medical staff and other health care providers respect patient autonomy, and the patients or surrogate's right to ongoing communications with the staff and professionals. Communications should include information about the patient's illness, prognosis, and options for treatment. This information should be presented in a manner that the patient or surrogate can understand, including information that a requested intervention is deemed by the staff/providers to be medically ineffective (futile) under the patient's particular circumstances.

C. Health care providers shall document the substance of patient or surrogate communications that determine treatment goals, the changes and resolutions of these goals.

D. TRMC health care providers have the right to refuse to be involved in the provision of treatments that violate their own values or conscience.

E. In the event of a conflict between the medical staff/health care providers and the patient or surrogate regarding the medically ineffective (futile) status of a proposed or continued intervention, the physician or care providers shall seek conflict resolution. The physician or care providers may seek ethics consultation. The ethics consultation will attempt to mediate a resolution and will give a non-binding opinion. The attending physician will determine if the intervention is medically ineffective (futile).

F. Interventions considered clinically to be life-sustaining should be evaluated in accordance with the procedure set forth in the TRMC policy (Discontinuing Life Support Services Policy # 12-3047).

IV. PROCEDURES

A. In the treatment decision making process, the physician and health care team should consider each individual patient's condition, goals, values, and beliefs. Communication between physician/care team and the patient or surrogate about these considerations should start early in the clinical course rather than at the time of crisis whenever possible.

B. The physician should be thoroughly knowledgeable of the patient's condition, prognosis, and the risks and benefits of applicable treatment. The physician should understand physician or patient values that might impact treatment.

C. Interventions considered being life sustaining should be considered under the provisions of TRMC policy (Discontinuing Life Support Services Policy # 12-3047).

D. The physician and the nursing care team should engage the patient or surrogate in the decision making process through ongoing communication. Risks and benefits of treatment are to be communicated. The efficacy of intervention options should be explained in an understandable fashion to patient or surrogate.

E. If the patient or surrogate continues to insist on an intervention or continuation of an intervention that has been deemed medically ineffective or contrary to generally accepted health care standards applicable to the health care provider or TRMC, the physician/care team may endeavor to resolve the conflict, including but not limited to:

1. Through a second opinion from an appropriate physician

2. Case Management

3. Nursing Services

4. Mediation via ethics consultation, or

5. Transfer to another physician or facility

F. If the conflict remains unresolved, an ethics consultation should be obtained. If review by the Ethics Committee supports the patient's position, and the physician remains unpersuaded, transfer of care within the institution may be arranged. If the Ethics review supports the physician's position, and the patient or proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution. If transfer is not possible, the intervention need not be offered.

G. California Probate Code 4763 provides as follows:

1. "A health care provider of health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following:

a. Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient.

b. Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision.

c. Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued."

V. GUIDING PRINCIPLES:

A. Meaningful patient autonomy

B. What is of benefit to the patient?

C. Do no harm to the patient

D. Always ask the question: "Is it just?"

E. Provide education, communication and participation of all parties involved for the welfare of the patient.

VI. REFERENCES

A. James J. Walter, Clinical and Organizational Ethics: "Medical Futility-an Ethical Issue for Clinicians and Patients." Practical Bioethics, Vol. 1, No. 3 Summer 2005.

B. California Consent Manual, Appendix 4. "Guidelines for Foregoing Life-Sustaining Treatment for Adult Patient.

C. Comprehensive Accreditation Manual for Hospitals; Title 22: 70707 (b6), 70707 (b6).

D. Policy on Medical Futility and End-of-Life Care, Brigham and Women's Hospital of the Harvard Medical School, 2003.

E. California Probate Code 4735 provides as follows:

"A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution."

VII. REFERENCED DOCUMENTS

A. Discontinuing Life Support Services - RMC Policy # 12-3047

B. Discontinuation of Life Sustaining Treatments - Community Medical Center (CMC) Policy # 11930

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Medical Futility

Descriptive Type: RenewalNew Policy

Document Number: 12-1051

Attachments: None

Author: Bill Busch (Ethics Committee)

Typist: Julie GreshamAndrea Carrasco

Creation Date: 10/26/10

Revision Date: 01/18/18

Prev. Dist. Date: 01/27/11None

Committee Review and Approval:	Approval Date:	Comments:
Ethics Committee	10/26/10	
MEC	01/12/11	
Board of Directors	01/26/11	

Effective Date: 01/27/11

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Health Care Decisions for Unrepresented Patients

I. Purpose:

The purpose of this policy is to provide a process for making ethically and medically appropriate treatment decisions on behalf of persons who lack health care decision-making capacity and for whom there is no surrogate decision-maker.

II. Preamble:

A. This policy guides health care professionals through a process to make medical treatment decisions on behalf of an incapacitated patient who lacks a surrogate decision-maker and when there is no known family member who is willing and able to make medical treatment decisions on behalf of the patient. Despite their incapacity, such "unrepresented " patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals.

B. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency in these cases within our hospital.

C. Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences must be in the patient's best interests, taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the hospital, or other affected parties. In this regard , appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-

beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.[i]

D. This policy is procedural in nature and applies to all medical decisions for which informed consent is usually required. This policy is meant to support the hospital's underlying consent policy.

E. Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions.[ii]

III. When Use of This Policy is Appropriate:

A. This policy may be used when the following conditions are met:

1. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) to lack capacity to make health care decisions. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate a health care decision. Conditions for which psychiatric or psychological treatment may be required do not, in and of themselves, constitute a lack of capacity to make health care decisions.

2. No agent, conservator, or guardian has been designated to act on behalf of the patient.

3. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision-maker.

4. No surrogate decision-maker or family member can be located who is reasonably available[iii] and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, Religious affiliation, and contacting public health or social service agencies known to have provided treatment for the patient.

5. Application of this section will be suspended during any period in which the hospital implements its disaster and mass casualty program, or its fire and internal disaster program.

B. This policy does not address the criteria for determining and appointing an appropriate decision-maker. And finally, this policy is not meant to be applied in emergency medical situations.

IV. Policy:

A. When use of this policy is appropriate (as outlined above) medical decisions will be made by a multi-disciplinary team of at least 7 persons whose members shall include, but not be limited to, individuals directly involved with the care of the patient. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, chair or vice-chair of the ethics committee, two non-medical (community) member of the ethics committee or other appropriate committee, as available and appropriate consulting clinicians, pastoral care staff, and a pharmacist.

B. In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:

1. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.

2. Determine appropriate goals of care by weighing the following considerations.

   a. Patient's previously-expressed wishes, if any and to the extent known.

   b. Relief of suffering and pain.

   c. Preservation or improvement of function.

   d. Recovery of cognitive functions.

   e. Quality and extent of life sustained.

   f. Degree of intrusiveness, risk or discomfort of treatment.

   g. Cultural or religious beliefs, to the extent known.

3. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments

4. Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.

5. Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law.[iv] [v]

6. The multi-disciplinary team must assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.

C. Agreement of Treatment:

1. If all members of the multi-disciplinary team agree to the appropriateness of the treatment, it shall be provided.

2. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treatment physician.[vi]

C. Disagreement on Treatment:

1. If the members of the multi-disciplinary team disagree about the care plan, the ethics committee will be called to explore their disagreement and facilitate resolutions.

   a. If agreement is reached either to provide or to forgo treatment, the decision of the multi-disciplinary team then becomes final.
   b. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved.[vii] Court-

imposed legal remedies should only be sought in extreme circumstances and as a last resort.

c. In all cases, appropriate pain relief and other palliative care shall be continued.

D. Exceptional Circumstances:

1. Legal counsel should be consulted if a decision to withdraw or withhold treatment is likely to result in the death of the patient and the situation arises in any of the following circumstances:

a. The patient's condition is the result of an injury that appears to have been inflicted by a criminal act.

b. The patient's condition was created or aggravated by a medical accident.

c. The patient is pregnant.

d. The patient is a parent with sole custody or responsibility for support of a minor child.

E. Documentation:

1. Signed, dated and timed medical record progress note will be written for the following:

a. The findings used to conclude that the patient lacks medical decision-making capacity.

b. The findings that there is no advance health care directive, no conservator, guardian or other available decision-maker, and no health care instructions, in the patient's medical record or other available sources.

c. The attempts made to locate surrogate decision-makers and/or family members and the result of those attempts.

d. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment.

e. Any information from the ethics committee or other consult, should it be convened.

End Notes:

[i] California Probate Code Section 4735 states that: "A health care provider or health care institution may decline to comply with an individual health care instruction or health care decision that requires medically ineffective health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution." See Policy.

[ii] California Probate Code Section 4650(c) states that: "In the absence of controversy, a court is normally not the proper forum in which to make health care decisions, including decisions regarding life-sustaining treatment."

[iii] California Probate Code Section 4717 states that: "(a) Notwithstanding any other provision of law, within 24 hours of the arrival in the emergency department of a general acute care hospital of a patient who is unconscious or otherwise incapable of communication, the hospital shall make reasonable efforts to contact the patient's agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient. A hospital shall be deemed to have made reasonable efforts and to have discharged its duty under this section, if it does all of the following:

(1) Examines the personal effects, it any, accompanying the patient and any medical records regarding the patient in its possession, and reviews any verbal or written report made by emergency medical technicians or the police, to identify the name of any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient.

(2) Contacts or attempts to contact any agent, surrogate, or a family member or other person the hospital reasonably believes has the authority to make health care decisions on behalf of the patient, as identified in paragraph (1).

(3) Contacts the Secretary of State directly or indirectly, including by voice mail or facsimile, to inquire whether the patient has registered an advance health care directive with the Advance Health Care Directive Registry. If the hospital finds evidence of the patient's Advance Health Care Directive Registry identification card either from the patient or from the patient's family or authorized agent.

California Probate Code Section 4736 states that: "A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following: (a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient. (b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts

to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or decision. (c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued."

[iv] California Probate Code Section 4617 states that: "'Health care decision' means a decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following: (a) Selection and discharge of health care providers and institutions. (b) Approval or disapproval of diagnostic test, surgical procedures, and programs of medication. (c) Direction to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation."
California Probate Code Section 4683 states that: "Subject to any limitations in the power of attorney for health care: (a) An agent designated as the power of attorney may make health care decisions for the principal to the same extent the principal could make health care decisions if the principal had the capacity to do so. (b) The agent may also make decisions that may be effective after the principal's death, including the following: (1) Making a disposition under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code). (2) Authorizing an autopsy under Section 7113 of the Health and Safety Code. (3) Directing the disposition of remains under Section 7100 of the Health and Safety Code. (4) Authorizing the release of the records of the principal to the extent necessary for the agent to fulfill his or her duties as set forth in this division.

[v] California Probate Code Section 4652 states that: "This division does not authorize consent to any of the following on behalf of a patient: (a) Commitment to or placement in a mental health treatment facility. (b) Convulsion treatment (as defined in Section 5325 of the Welfare and Institutions Code). (c) Psycho-surgery (as defined in Section 5325 of the Welfare and Institution Code). (d) Sterilization. (e) Abortion."

[vi] California Probate Code Section 4734 states that: "(a) A health care provider may decline to comply with an individual health care instruction or health care decision for reasons of conscience. "(b) A health care institution may decline to comply with an individual health care instruction or health care decision if the instruction or decision is contrary to a policy of the institution that is expressly and based on reasons of conscience and if the policy was timely communicated to the patient or to a person then authorized to make health care decisions for the patient."

[vii] California Probate Code Section 4736 states that: "A health care provider or health care institution that declines to comply with an individual health care instruction or health care decision shall do all of the following: (a) Promptly so inform the patient, if possible, and any person then authorized to make health care decisions for the patient. (b) Unless the patient or person then authorized to make health care decisions for the patient refuses assistance, immediately make all reasonable efforts to assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instruction or

decision. (c) Provide continuing care to the patient until a transfer can be accomplished or until it appears that a transfer cannot be accomplished. In all cases, appropriate pain relief and other palliative care shall be continued."

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Health Care Decisions for Unrepresented Patients

Descriptive Type: Revision~~New Policy~~

Document Number: 12-1052

Attachments: None

Author: Ethics Committee

Typist: ~~Julie Gresham~~Andrea Carrasco/Ena Menezes

Creation Date: 10/01/2010

Revision Date: 01/18/18

Prev. Dist. Date: ~~None~~06/21/12

Committee Review and Approval:	Approval Date:	Comments:
Ethics Committee	~~05/24/12~~	
MEC	~~06/13/12~~	
Board of Directors	~~06/20/12~~	

Effective Date: ~~06/21/12~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

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TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Hospitalist Coverage of Private Patients for Primary Care Physicians

PURPOSE: This policy outlines the coverage/guidelines for private patients for Primary Care Physicians by a Hospitalist.

POLICY:

A. Weekend Coverage:

1. 5-day advance notice of request for weekend coverage, except for urgent/emergent situations
2. Care of current inpatients will begin at 5 pm on Fridays
3. Admission of new patients will begin at 5 pm on Fridays
4. Current inpatients will be handed back to Primary Care Physician on Mondays or when Primary Care Physician returns
5. New admits over the weekend will be followed by Hospitalist until discharge
6. Mandatory doctor-to-doctor sign out before all handoffs. Must be in person or via phone
7. Hospitalist will bill for all services provided during the days/nights covered

B. Weekday/Holiday Coverage:

1. 5-day advance notice of request for coverage, except for urgent/emergent situations
2. All admissions must be through Emergency Room
3. Current inpatients will be handed back to Primary Care Physician when Primary Care Physician returns
4. New admits will be followed by Hospitalist until discharge
5. Mandatory doctor-to-doctor sign out before handoffs. Must be in person or via phone
6. Hospitalist will bill for all services provided during the days/nights covered

C. Emergency Coverage:

1. Provide as much notice as possible depending on the emergency situation
2. Utilization will be monitored
3. Care of current patients and admission of new patients will commence at the agreed upon time between Hospitalist and Primary Care Physician

4. Current inpatients will be handed back to Primary Care Physician when Primary Care Physician returns
5. New admits will be followed by Hospitalist until discharge
6. Mandatory doctor-to-doctor sign out before handoffs. Must be in person or via phone
7. Hospitalist will bill for all services provided during the days/nights covered

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Hospitalist Coverage of Private Patients for Primary Care Physicians

Descriptive Type: ~~New Policy~~Renewal

Document Number: 12-1055

Attachments: None

Author: Warren Hosseinion, M.D.
Patricia Mathewson, RN, CCO/CNO

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 06/07/12

Revision Date: 1/30/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~09/12/12~~	
Board of Directors	~~09/26/12~~	

Effective Date: ~~09/27/12~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Latex Allergy and Sensitivity

I. Purpose:

To define Tulare Local Health Care District (TLHD), dba Tulare Regional Medical Center management of patients with symptoms of latex sensitivity or allergy, a history of adverse reactions to latex or those who are at risk for latex reactions.

II. Policy Statement:

Tulare Local Health Care District (TLHD) provides a safe environment for its patients by reducing the risk of allergic/anaphylactic reaction to latex. Policies and procedures for caring for the latex sensitive patient provide direction for implementation of a latex safe environment.

III. Definitions:

A. Latex Alert: Patients known to have an increased exposure to latex (i.e., patients with myelodysplasia or urological deformities, those who have multiple surgical procedures, allergies to chestnuts; avocadoes; bananas; patients with Spina Bifida, myelomeningocele, or healthcare workers) are predisposed to having a hypersensitivity response to Latex.

B. Latex Allergic: Patients who have experienced a reaction to latex or latex containing products. Latex allergy is a sensitized response to Latex Protein Antigen from natural rubber sources. Latex antigens may be transmitted by direct contact with rubber/latex products and/or by airborne routes. Latex allergy may result from reaction (type IV, or delayed hypersensitivity) to rubber additives producing typically a rash at site of contact.

C. Latex Reaction: Exposure to Latex products may cause a hypersensitivity response either locally (i.e., contact dermatitis, cell-mediated reaction; sensitivity to latex products), or a systemic reaction (i.e., anaphylaxis, IgE medicated hypersensitivity) following exposure is defined as a Latex Allergy.

This may manifest as breathing difficulties (i.e., bronchospasm), cutaneous erythema and urticaria, anxiety, palpitations edema, shock, or cardiac arrest. This reaction can occur within minutes.

IV. Patients at Risk:

A. Patients with chronic bladder cauterizations.

B. Patients with occupational exposure (i.e. workers in the latex industry and healthcare workers).

C. Patients that have had multiple operations.

D. Patients with a history of atopy and multiple allergies.

E. Patients with a history of asthma, or hay fever.

F. Those patients that have experienced an anaphylactic reaction during surgery, urinary catheterization, rectal or vaginal examination and/or bladder stimulation.

V. Procedure:

A. Patient Identification:

1. Medical and nursing staff will elicit a history and assessment of latex allergy, documenting the patient's allergic response in the medical record and communicating the information to other health care providers. Patients at risk for latex allergy are those with known or suspected latex allergy or latex alert patients who are known as high risk, but with no history of latex allergy. Identification factors for known or suspected latex allergic patients may be: • Sneezing • Runny nose • Itchy, watery eyes • Urticaria • Angioedema • Bronchospasm on exposure to latex products

2. The appropriate provider will document latex allergy when entering orders to ensure pharmacy is informed about the latex allergy.

3. When it is determined that a patient has a latex sensitivity or allergy:

   i. Nursing staff will place a red allergy alert band on the same patient's limb as the patient identification band to signify the patient allergy-status. Staff will refer to the patient medical record to identify the type of allergy as latex.

ii. Nursing staff will label the front of the chart and place a latex precaution sign outside the door and above or on the patients' bed.

iii. Assign the patient to a private room, when feasible, to limit the potential for accidental exposure. If a private room is not available, both patients must receive a latex free environment.

B. Materials Management will maintain and deliver to patient care areas, a cart or container with latex free products. Operative Services, Emergency Services, Radiology, Endoscopy, Special Procedures, and Labor and Delivery will maintain a supply of clearly identified latex-free products relevant to their respective area.

C. Purchasing will review products containing latex and determine substitutes/alternatives with the assistance of Department Managers, Clinicians and/or Products Committee.

D. Materials Management will maintain the inventory catalog with latex information on all available products. The inventory catalog is available to staff in Materials Management office. A list of alternative products and supplies will also be available.

E. Hospital personnel caring for a latex sensitive/allergic patient will check all labels and packaging for latex/rubber content. Contact Materials Management or Supervisor for assistance when necessary.

F. Hospital personnel who have used latex products prior to attending to the latex sensitive/allergic patient will wash his/her hands before entering the latex sensitive/allergic patient's room.

G. If a latex product must be used, staff will place a cloth between the patient's skin and the latex product.

H. Staff will use only latex-free gloves for patient contact.

I. Communication between disciplines and departments will include information regarding the patient's allergy status. Staff will notify ancillary departments where procedures will be performed of patient's latex allergy status at the time of ordering/scheduling the procedure.

J. Radiology and other treatment areas will schedule procedures involving latex allergy patients as the first case of the morning to minimize exposure to airborne latex.

K. Information desk personnel and Department Managers will ensure that latex balloons are not used in the Medical Center. Mylar balloons are permitted.

L. Pharmacy will adopt the **"One-Puncture Rule"** in all patients in whom a latex allergy has been identified.

M. Patient and family education will be documented in the patient medical record.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

~~LATEX ALLERGY ASSESSMENT (Known/ Suspected Patients ONLY)~~

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274
559.688.0821 • www.TulareRegional.org

~~Patient Name:~~ _____ ~~MR #:~~

Ask the patient the following questions and explain:

~~Do you have or have you ever experienced:~~	~~Explain:~~
~~☐ Asthma~~	
~~☐ Hay Fever~~	
~~☐ Eczema~~	
~~☐ Problems with rashes~~	
~~☐ Hand rash that lasted longer than a week~~	
~~☐ Multiple surgeries~~	
~~☐ Spinal cord problems at birth~~	
~~☐ Exposure to latex in the workplace~~	
~~☐ An allergic reaction of unknown cause, especially during a medical or dental procedure~~	
~~**Allergies:**~~	~~**Explain:**~~
~~☐ Any type of allergy~~	
~~☐ Known rubber or latex allergy~~	
~~☐ Avocados~~	
~~☐ Chestnuts~~	
~~☐ Pears~~	
~~☐ Figs~~	
~~☐ Kiwi/ Passion fruits~~	
~~☐ Papaya~~	
~~☐ Tomatoes~~	
~~☐ Potatoes~~	

LATEX ALLERGY ASSESSMENT (Continued)

Have you ever experienced an allergic reaction: (itching, swelling, hives, rash, runny nose, wheezing, eye irritation, shortness of breath, other)	
☐ During a dental examination or procedure	
☐ During a rectal examination	
☐ During a vaginal examination	
☐ During any medical examination	
☐ After a bladder catheterization	
☐ After an examination by a healthcare professional wearing rubber or latex gloves	
☐ After contact with a condom	
☐ After contact with a diaphragm	
☐ During or after wearing rubber gloves	
☐ After touching or blowing up a balloon	
☐ After contact with any latex or rubber product	

IF A LATEX ALLERGY IS CONFIRMED OR SUSPECTED, THE REGISTERED NURSE WILL:

- Place an allergy sticker on the front of the patient's chart. The words "Latex Allergy" will be posted on the patient's bed and on the patient's door.
- Non – latex products will be substituted for those products containing latex.
- All departments will be notified of the patient's latex allergy, including Nutritional Services.

Place Original in Medical Record

PATIENT LABEL HERE

~~LATEX AND NON-LATEX ALTERNATIVES~~

~~LATEX~~	~~NON-LATEX ALTERNATIVE~~
~~Gloves:~~	~~Gloves:~~
• ~~Neutralon (Perry)~~ • ~~Triflex (Baxter)~~ • ~~Blogel (Regent)~~ • ~~Unsterile Exam Gloves~~ • ~~Gloves in Prep Tray~~	• ~~Neolon (BD)~~ • ~~Triflex Sterile Vinyl Gloves (Baxter)~~ • ~~Elastyren (Danpren)~~ • ~~Tactylon~~
~~Catheters:~~	~~Catheters:~~

• ~~Robnel (red rubber)~~
• ~~Latex Catheters:~~
  ○ ~~Foley Catheter Kits~~
  ○ ~~Malecot~~
  ○ ~~Mushrooms~~
• ~~Leg Urine Drainage Bag (discard rubber strap)~~
• ~~Reliavac (Hemovac reservoir)~~
• ~~Penrose Drain~~
	• ~~Feeding Tubes (Bard)~~
	• ~~Blake Drains (J & J)~~
	• ~~Hemovac Drain w/o Reservoir (Davol)~~
	• ~~Granade Reservoir (Davol)~~
	• ~~Cysto Tubing (cut latex rubber adaptor off the tubing)~~
	• ~~Silastic Foley (Bard)~~

~~Drapes:~~	~~Drapes:~~
	• ~~Steri Drapes (3M)~~ • ~~Ioban Drapes (3M)~~ • ~~Extremity Sheet (Baxter)~~ • ~~Split Sheet (Baxter)~~ • ~~U – Drape (Baxter)~~ • ~~Lap Sheet (Baxter)~~

Descriptive Name: Latex Allergy and Sensitivity

Descriptive Type: ~~New~~Revision

Document Number: 12-1057

Attachments: ~~Latex Allergy Assessment~~
~~Latex and Non-Latex Alternatives~~None

Author: Pat Speers/Andrea Carrasco/Ena Menezes

Typist: ~~Pat Speers/Julie Gresham~~Andrea Carrasco

Revision Date: 01/19/18

Creation Date: 07/04/13

Previous Dist. Date: ~~None~~02/27/14

Committee Review and Approval:	Approval Date:	Comments:
Patient Safety Committee	~~02/16/14~~	
MEC	~~02/12/14~~	
Board of Directors	~~02/26/14~~	

Effective Date: ~~02/27/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services (ICU)

FROM: Administration

SUBJECT: ICU Policy – ICU Committee

PURPOSE: The Intensive Care Unit (ICU) Committee has been established to monitor the activity of the unit, including patient care, education and utilization of services.

COMPOSITION: The Intensive Care Unit (ICU) Committee shall consist of the Medical Director of ICU, ICU Clinical Director, Case Manager, Clinical Director of Respiratory Therapy, Medical Director of Respiratory Therapy, members of the Medical Staff, Director of Pharmacy, and the Chief Nursing Officer.

FUNCTIONS:

A. Insure efficient and appropriate utilization of ICU services.

B. Develop and/or review applicable policies/procedures.

C. Review the quality of patient medical management.

D. Review patient or staff related problems.

E. Act as a teaching nucleus for ICU medical and nursing staff.

F. Review and recommend changes in Code Blue policy and procedure.

G. Coordinate appropriate problems with the Performance Improvement Committee.

MEETING: The Committee shall meet at least quarterly and shall prepare and maintain a permanent record of its proceedings.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: ~~08/25/11~~

APPROVED:

Medical Executive Comm.: ~~08/10/11~~

Board Of Directors: ~~08/24/11~~

(12) Clinical Services
Inpatient Care Unit: ICU
ICU Policy – ICU Committee
12-3003.4

POLICY/GUIDELINE MANUAL

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: ICU Policy – ICU Committee

Descriptive Type: Revised

Document Number: 12-3003.4

Attachments: None

Author: ~~Danita Brill~~Angie Graziano

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 08/11/10

Revision Date: 01/19/18

Prev. Dist. Date: 08~~12~~/2~~59~~/11~~05~~

Committee Review and Approval:	Approval Date:	Comments:
ICU Comm.	~~02/28/11~~	
Medicine Service	~~03/16/11~~	
MEC	~~08/10/11~~	
Board of Directors	~~08/24/11~~	

Effective Date: ~~08/25/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: ICU Policy – Admission, Discharge and Transfer Criteria

I. PURPOSE:

A. The primary utilization of the Intensive Care Unit (ICU) is for the continuous monitoring and care of critically ill adults. This policy for admission to, and discharge from, the Intensive Care Unit is established to provide criteria for priority determination, and appropriate utilization of Intensive Care services. The Admitting physician and/or ICU Medical Director Intensivist have the final decision regarding the admission/discharge of patients not meeting these criteria.

II. PROCEDURE:

A. Criteria for Admission:

1. Cardiac System;

a. Acute Myocardial infarction with complications

b. Cardiogenic Shock

c. Complex arrhythmias requiring close monitoring and intervention

d. Acute congestive heart failure with respiratory failure and/or requiring hemodynamic support

e. Hypertensive emergencies

f. Unstable angina, particularly with dysrhythmias, hemodynamic instability, or persistent chest pain

g. Post cardiac arrest

h. Cardiac tamponade with hemodynamic instability

i. Complete heart block

j. Hemodynamic monitoring

2. Pulmonary System:

a. Acute respiratory failure requiring ventilator support

b. Pulmonary emboli with hemodynamic instability

c. Patients in Telemetry who are demonstrating respiratory deterioration

d. Need for nursing/respiratory care not available in lesser care areas such as floor or intermediate

e. Massive hemoptysis

f. Respiratory failure with imminent intubation

2. Neurologic Disorders:

a. Stroke with altered mental status, unstable Glasgow Coma Scale requiring neurological assessment every hour or more frequently

b. Meningitis with altered mental status or respiratory compromise

c. Brain-dead or potentially brain-dead patients who are being aggressively managed while determining organ donation status

3. Drug Ingestion and Drug Overdose

a. Hemodynamically unstable drug ingestion

b. Drug ingestion with significantly altered mental status with inadequate airway protection

c. Seizures following drug ingestion

4. Gastrointestinal Disorders

a. Life-threatening gastrointestinal bleeding including hypotension, angina, continued bleeding, or with comorbid conditions

b. Fulminant hepatic failure

c. Severe pancreatitis

5. Endocrine

a. Diabetic ketoacidosis complicated by hemodynamic instability, altered mental status, respiratory insufficiently, or severe acidosis

b. Hyperosmolar state with coma and/or hemodynamic instability

c. Sever hypercalcemia with altered mental status, requiring hemodynamic monitoring

d. Hypo- or hypernatremia with altered mental status

e. Hypo- or hypermagnesemia with hemodynamic compromise or dysrhythmias

f. Hypo- or hyperkalemia with dysrhythmias or muscular weakness

g. Hypophosphatemia with muscular weakness

6. Surgical

a. Postoperative patients requiring hemodynamic monitoring/ventilator support or extensive nursing care

7. Pediatric Patients

a. Pediatric patients (<14 years of age) may be admitted to ICU and will be assigned a Pediatric nurse for 1:1 care, with the assistance from ICU RN.

b. All pediatric admissions to ICU will be reviewed for appropriateness of admission by the ICU Committee.

c. **EXCEPTIONS TO ADMISSION**: Acute Neurotrauma will immediately transfer to a specialized neurotrauma facility.

d. The following pediatric patients will be admitted to ICU for treatment/observation **ONLY UNTIL TRANSPORT TO A SPECIALIZED PEDIATRIC ICU OR OTHER DEFINITIVE CARE FACILITY CAN BE ARRANGED:**

1. Acute trauma involving the head and/or chest, or resulting in unstable cardiac or respiratory function.

2. Intubated, requiring continuous mechanical ventilation.

3. Any physiological condition resulting in cardiac or respiratory arrest.

8. Miscellaneous

a. Septic shock with hemodynamic instability

b. Clinical conditions requiring ICU-level nursing care

c. Environmental injuries (Lightning, near drowning, hypo/hyperthermia)

B. Objective Parameters:

1. Vital Signs

a. Pulse < 40 or > 150 beats/min

b. Systolic arterial pressure < 80mm Hg or 20 mm Hg below the patient's usual pressure

c. Mean arterial pressure < 60 mm Hg

d. Diastolic arterial pressure> 120 mm Hg

e. Respiratory rate > 35 breaths/min

2. Laboratory Values (newly discovered)

a. Serum sodium < 110 mEq/L or > 170 mEq/L

b. Serum potassium < 2.0 mEq/L or > 7.0 mEq/L

c. Pa02 < 50

d. PH < 7.1 or > 7.7

e. Serum glucose > 800 mg/dL

f. Serum calcium >15 mg/dL

g. Toxic level of drug or other chemical substance in a hemodynamically compromised patient

3. Radiography/Ultrasonography/Tomography (newly discovered)

a. Cerebral vascular hemorrhage or contusion

b. Ruptured esophageal varices with hemodynamic instability

4. Electrocardiogram

a. Myocardial infarction with complex arrhythmias, hemodynamic instability or congestive heart failure

b. Sustained ventricular tachycardia or ventricular fibrillation

c. Complete heart block with hemodynamic instability

5. Physical Findings (acute onset)

a. Unequal pupils in an unconscious patient

b. Burns covering < 10% body surface area

c. Anuria

d. Airway Obstruction

e. Cyanosis

f. Cardiac tamponade

III. Procedure for Admission:

A. The Nursing Supervisor will consult on all patient admits to the ICU to determine bed availability, effective staffing levels, and coordinate patient triage as needed with the ICU medical Director/Intensivist.

1. All patients must have physician orders on the chart or in the Electronic Medical Record to be admitted to, transferred into or out of, or discharged from the ICU.

2. Upon patient transfer into or out of ICU, all previous orders will automatically be canceled and new orders written.

3. Patients **WILL NOT BE PLACED IN "OBSERVATION STATUS"** in the ICU.

4. All patients admitted to the ICU will be evaluated by a physician or surgeon in a time-frame which will permit a reasonable and prudent response, but, no greater than eight (8) hours (time starts when patient enters ICU).

5. Orders will be given by attending physician or his physician delegate on admission.

6. Visiting hours are made outside of the hospital's normal patient visitation hours and considered case by case on the individual needs of the patient. Visitation is limited during staff shift change each day from 6:30-8:30 a.m. & p.m.

7. **Consultations** are at the discretion of the attending physician. Consultations, when appropriate, are obtained within 24-48 hours. The primary physician assumes the responsibility for obtaining consultation.

   a. The attending physician is the physician-in-charge unless that responsibility is relinquished to another physician. Any change in the primary care physician will be noted in the medical record.

   b. Intensivist will be available for consultation. They will follow all patient stays in the ICU and make recommendations to the attending physicians as needed.

8. **Bed Utilization:** In the event of a bed shortage, the ICU Director or designee will consult with the Nursing Supervisor and physicians of patients in the ICU to identify candidates for transfer. If there are none, the Medical Director of ICU or Intensivist will be consulted with report of the current patients and their status, and a decision will be made regarding candidates to transfer.

   a. Patients designated "No Code Blue" and not receiving ICU-specific therapy, will be considered candidates for transfer.

   b. Questions or concerns regarding triage decisions will be referred to the ICU Medical Director or Intensivist, and may be reviewed by the ICU Medical Staff Committee.

IV. Discharge/Transfer Criteria:

1. Stable EKG/cardiac rhythm for at least 12 hours, defined as:

   a. Resolution of acute EKG changes indicating acute or impeding myocardial infarction, or unstable ischemia.

   b. Maintains stable EKG and cardiac rhythm without continuous infusion of intravenous vasoactive or anti-arrhythmic medications. Chest pain/Myocardial Infarction ruled out via 3 sets of negative cardiac enzymes.

2. Hemodynamically stable for at least 12 hours, maintains systolic blood pressure >90 and <180 mmHg, or heart rate >50/minute, with stable, low-dose intravenous vasoactive drugs (**to Post-ICU only).**

   a. No invasive monitoring required

   b. Resolution of potential for hemodynamic compromise due to acute condition.

3. Respiratory stability (off Continuous Mechanical Ventilation), for at least 12 hours as defined as:

   a. Maintains adequate oxygenation, defined as PaO2>90, with FiO2<50% (unless chronically hypoxic, then as defined by physician).

   b. Maintains adequate ventilation, with PaCO2<70 (unless chronically hypercarbic, then determined by physician).

   c. Requires pulmonary intervention every 4 hours or less frequently.

4. Neurologically stable for at least 12 hours, defined as:

   a. Glasgow Coma Scale score improved or unchanged, requiring reassessment every 4 hours or less frequently.

5. Resolution of multisystem organ failure, with hemodynamic, respiratory, and neurologic stability for at least 12 hours as defined in No.4 above.

6. Resolution of metabolic or electrolyte imbalance and renal failure, for at least 12 hours, defined as:

   a. Metabolic. Electrolyte, and renal diagnostic studies within normal limits (unless chronically abnormal, then as defined by physician).

7. Drug or chemical overdose/ingestion/toxicity: absence of related complications (as described above), for at least 12 hours.

8. **Procedure for Discharge/Transfer:** All patients transferred out will be accompanied by an appropriate staff member. ~~licensed nurse~~, ~~a~~ The patients nurse will give a complete SBAR report of the patient's condition ~~will be given~~ to the receiving nurse.

9. Patients that are to be discharged from the hospital directly from ICU will be discharged according to the hospital policy.

V. Quality Improvement Monitoring:

ICU Admission/Discharge criteria will be used in the ICU Committee PI Program, on a retrospective basis, to assess appropriateness of ICU bed utilization. Unsupported variations from these criteria will be reviewed and forwarded to the appropriate department chairman for review and follow-up.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: ICU Policy – Admission, Discharge and Transfer Criteria

Descriptive Type: Revised

Document Number: 12-3003.5

Attachments: None

Author: Angie Graziano/Andrea Carrasco/Ena Menezes

Typist: ~~Julie Gresham~~Andrea Carrasco

Creation Date: 3/13/14

Revision Date: 01/19/18

Prev. Dist. Date: 05~~2~~/2~~93~~/14~~2~~

Committee Review and Approval:	Approval Date:	Comments:
ICU/IM Committee	~~04/29/14~~	
MEC	~~05/14/14~~	
Board of Directors	~~05/28/14~~	

Effective Date: ~~05/29/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

Effective Date: #13-9026

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Newborn Screening Policy and Procedure

I. STANDARD OF CARE: Every infant will have a Newborn Screening Specimen collected by clinical personnel who have been educated regarding collection techniques and documentation requirements.

II. PURPOSE: Newborn Screening is intended to prevent the long term effects of disease through early identification and treatment. Screening is recognized as an essential preventive public health measure. Every state and US territory has established a program to screen newborns for certain disorders, although the scope of these programs varies from state to state. California's stated mandated newborn screening program began in 1/1996 and has expanded over the years

III. POLICY:

A. Every newborn under 6 days of age, including those not born in the hospital but admitted or transferred to the hospital within the first six days of age, shall have a blood specimen obtained in the approved manner for the state mandated newborn screening program as ordered in the Newborn or NICU standing orders. It should be noted that 12 hours to 6 days is the appropriate time for the collection of blood for the newborn screening test.

B. If an infant under 30 days of age is admitted to the hospital, there must be verification on the medical record that the test has been done, otherwise the test must be done within 48 hours of admission. Physician must be notified,

C. The brochure, ***Important Information for Parents about the Newborn Screen Test*,** is to be provided to each mother upon the first visit with the newborn.

D. California's testing methodology requires that newborns be at least 12 hours of age at the time of specimen collections. According to stated guidelines,

babies whose specimens were collected before 12 hours of life must have another screen.

E. **Discharge before 12 hours of age and parental refusal newborn screening is** mandated by state law, and all newborns must be tested. The only legal ground for refusal is when screening conflicts with religious beliefs and practices. Parents who refuse newborn screening for their infant must complete and sign **the newborn** screen test refusal form (NBS-TR) they should discuss this decision with the infant's health care provider. The hospital must complete and send to the Genetic Disease Branch the "**Hospital Report of Newborn Screen Specimen Not obtained" (NBS-NO) along with NBS-TR.**

F. **Missed specimens –The hospital must complete and send to Genetic Disease Branch the "Hospital Report of Newborn Screen Specimen Not obtained" (NBO-NO).**

G. **Transfer to another facility before 6 days of age:** The receiving facility is responsible for collecting a newborn screening specimen on or before the 6th day of life per state regulations. The transferring hospital must complete and send to the Genetic Disease Branch **the "Hospital Report of Newborn Specimen Not Obtained: (NBS-NO).**

H. **BLOOD TRANSFUSIONS:** Whenever possible a NBS specimen should be collected prior to giving blood. If the pre- transfusion specimen is collected prior to 12 hours of age, another specimen must be collected at least 24 hours after the transfusion(and before 6 days of age) **IF** hgb/hct≥ 10/30. If no pre-transfusion specimen is obtained, a specimen must be collected at least 24 hours after the transfusion and before 6 days of age **IF** hbg/hct ≥ 10/30.

I. **TERMINAL CONDITONS:** by state regulations, infants diagnosed at birth with a terminal condition and life expectancy of less that 1 month do no need a newborn screen. The hospital must complete and send to the Genetic Disease Branch the "Hospital Report of Newborn Screen Specimen Not Obtained' (NBS-NO).

J. Only capillary (heel stick) blood specimens should be used for newborn screening.

K. Medical records are responsible to review every newborns record within14 days from the date of discharge. If the newborn screening results have not been received, a **Newborn Screening Result Form** (**NBS-MR)** is to~~o~~ be ~~-~~sent to the state within 5 days of discovery.

L. Technique is important in obtaining and adequate filter paper specimen-(see procedure below).

M. Proper drying is equally important:

- Place on a flat clean surface to dry
- Air dry at room temperature for at least 3 hours
- Avoid heat, direct sunlight and humidity
- Do not refrigerate

N. Shipping: Special mailing envelopes are provided by GSO. More than one specimen can be placed in the envelope, providing the blood spots do not touch each other. There will be no batching of specimens. Specimens should be mailed to designated laboratory as soon as possible even if you only have 1or 2 for the day. (Make sure that all specimens are logged in on the nursery newborn screening specimen log in the nursery on the clipboard.)

- Complete the specimen transport log, as usual, listing all the specimens that will be included in the envelope.
- Put the specimens and the specimen transport log in the GSO envelope or regular manila envelope.
- Apply a shipping label to the envelope. Put the envelope in the designated place for pick up.GSO will automatically pick up at the time arranged.
- Stick the GSO tracking number on your copy of the transport log for your records in case you need to track the package/envelope. Place copy in newborn screening binder at desk by unit secretary.
- To request mailing supplies please call GSO.

O. Any specimen that is deemed unsuitable for testing will be rejected by the testing laboratory. The infant will be located and asked to return to TRMC for a repeat screen. That screen will be mailed out with the screens in the newborn nursery being mailed out for the day. Record the repeat specimens on the specific log sheet located at the back of the newborn screening clipboard in the nursery.

- MOST COMMON REASONS FOR REJECTED TESTS:
- Circles not completely filled.
- Blood not soaked through
- Clots on the sample surface
- Blood spread unevenly, “caked on” or Layered”
- Improper drying (blotting caused by closing the form before blood dries)

P. Newborn Screening is a joint responsibility of the following departments, medical, nursing, and medical records.

- Area Genetic Center Telephone number ASC-96 CHCC Madera California
- Phone 559-353-6416 / fax 559-353-6403.

IV. EQUIPMENT NEEDS:

- Tenderfoot heel incision device
- Alcohol swab
- Band-aid
- Sterile gauze
- Floor exam gloves
- Newborn Screening form completely filled out
- Heal Warmer (optional)

V. PRESCRIBED ACTION

STEPS OF PROCEDURE	POINTS OF EMPHASIS
• Check the amount of time since birth.	• Infant must be at least 12 hours old before doing the newborn screen but, (before the 6th day of life) • Critically ill newborns should be postponed until the newborn is stabilized.
• Don gloves –puncture heel with disposable tender foot heel devise on lateral aspect of infant's heel	• Warming heel may be helpful
• Cleanse skin with alcohol wipe and dry with 2x2.	
• Allow a drop of blood to accumulate and wipe off with 2x2 • Apply blood drop to one side of the filter paper until the circle is completely filled when viewed from both sides. • Completely fill all circles on filter paper collection form • Allow blood spots to air dry for at least 3 hours in a horizontal and preferable elevated position.	• Avoid squeezing the tissue to obtain blood as this may dilute the specimen as well as bruise the infant's heel. • Avoid touching the blood collection area or filter paper prior to, during, and following samples. • DO not let specimen come in contact with any surfaces, direct heat or sunlight. DO NOT refrigerate the samples. • Form should be double checked by person mailing it to make sure all the blanks are filled.

• Computer printed results with normal findings are mailed to the physician provider (PCP) and Medical records. • After receipt of results for the California Newborn Screening Program, Medical records will correlate the results with the log book. • The Medical Records Dept. is responsible for reviewing each newborns medical record within 14 days to assure receipt of results of NBS panel. If results not returned in 2 weeks, a missing newborn screening test results (**NBS-MR**) will be completed by Medical Records **and then sent to the state.**	

VI. DOCUMENTATION

A. NBS will be documented in the nurse's notes in ~~OBIX, the newborn discharge~~the electronic medical record ~~summary~~ and the NBS log.

B. The yellow copy will be placed in the medical record.

C. Nurses will indicate on a charge slip when test is performed for charge purposes.

D. Charge for the test will be determined by the state on an annual basis. TRMC will not collect more than the State recommended fee.

VII. REFERENCES:

California Newborn Screening Program, Children's Hospital Central California Area Service Center, Orientation/Annual update.

California Code of Regulations (title 17, Division1, Chapter 4, subchapter 9 sections 6500-6508)

National committee for clinical laboratory standard (NCCLS), Blood collection on filter paper for newborn screening programs.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Newborn Screening Policy and Procedure

Descriptive Type: Revised

Document Number: 12-3006

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 02/17/08

Revision Date: 08/24/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatric Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders – 5 and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Nursing Services

FROM: Administration

SUBJECT: Reprocessing and Reuse of Single-Use Devices

PURPOSE: To assure quality is incorporated into devices being reprocessed.

BACKGROUND: The "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" document provides guidance to third party and hospital reprocessors about their responsibility as manufacturers engaged in reprocessing devices labeled for single use under the Federal Food, Drug, and Cosmetic Act (the Act), as amended by the Safe Medical Devices Act of 1990, the Medical Device Amendments of 1992, and the Food and Drug Modernization Act of 1997. Third party and hospital reprocessors of single-use devices are subject to all the regulatory requirements currently applicable to original equipment manufacturers, including premarket submission requirements (Sections 513 and 515 of the Act; 21 Code of Federal Regulations Parts 807 and 814).

POLICY:

I. Tulare Regional Medical Center participates in third party reprocessing with third party reprocessors who are registered with the FDA:

A. Pursuant to FDA Guidelines Tulare Regional Medical Center does not reprocess or reuse single-use/disposable devices unless performed with a bone-fide third party reprocessor and with approval of the Product Evaluation Committee and Infection Prevention and Control Program for each specific item to undergo reprocessing.

II. Single-use devices at Tulare Regional Medical Center reprocessed by an FDA approved third-party reprocessor:

A. On July 28th, 2010 the Tulare Regional Medical Center Product Evaluation Committee approved third party reprocessing of FDA Class II single-use devices (i.e. sequential compression device sleeves; oxygen saturation probes; disposable blood pressure cuffs; and disposable tourniquets).

B. Single-use devices are secured in a bin designated for reprocessing after use

C. A representative from the third-party reprocessor performs hospital-wide rounds to remove single-use devices for reprocessing at their processing Plant.

III. Reprocessing

A. The third-party reprocessor is responsible for performing:

a. Identity Control – identifying devices with individualized serial numbers to ensure control during the life-cycle of each device

b. Disassembly – disassembly of devices to their base elements to facilitate cleaning and inspection

c. Comprehensive cleaning – validating cleaning processes that render the component safe for use

d. Visual Inspection – inspection of a variety of equipment including bore and video microscopes to identify compromised components

e. Reassembly – using only components that pass stringent tolerances, finished devices are assembled

f. Functional performance testing – 100% of all devices are functionally tested to ensure like-new performance

g. Packaging and sterilization – devices must meet all industry standards for packaging and sterilization.

h. Guaranteed safety – multiple 501(k) clearances that the remanufactured devices will perform equivalent to the originals

IV. Oversight:

A. Materials Management will assure third party reprocessor has FDA approval.

B. Materials Management will provide oversight for activities related to third party reprocessing.

POLICY / GUIDELINE

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Reprocessing and Reuse of Single-Use Devices

Descriptive Type: Revised

Document Number: 12-3013

Attachments: None

Author: ~~Paul Stratman/Troy Salazar~~Celeste Terronez

Typist: Melissa Arend

Creation Date: 03/26/09

Revision Date: ~~09/13/16~~ 1/17/18

Prev. Dist. Date: 09/27/12

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention and Control	~~11/14/16~~	
MEC	~~12/14/16~~	
Board of Directors	~~01/25/17~~	

Effective Date: ~~01/26/17~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services (Nursing) and Admissions

FROM: Administration

SUBJECT: Pediatric Admission

I. PURPOSE:

In an effort to facilitate the expeditious admission of pediatric patients to the hospital, the following policy is established.

II. POLICY:

A. Pediatric patients will include children from newborn to thirteen (13) years of age. Patients who are from the age of fourteen (14) to eighteen (18) years of age will not be routinely admitted to the Pediatric Unit. However, these patients should be admitted to the third floor Medical/Surgical unit when possible.

B. When a child comes to the unit without orders, the receiving nurse shall contact the attending physician after brief initial assessment and vital signs to obtain orders.

C. The admitting physician shall, on a timely basis, communicate with the nursing staff regarding the child's condition.

D. All emergency admissions will be directly admitted to the Nursing Unit to avoid delay in treatment.

E. Pediatric patients age three (3) and under shall be placed in a crib unless the child is exceptionally large for his age or otherwise ordered.

F. Parents may stay with the child unless the patient's diagnosis precludes it. Nursing staff shall attempt to involve the parents in the child's care as much as possible.

G. Nursing staff shall report any adverse change in the child's condition to the physician on a timely basis.

Effective Date: ~~09/25/14~~

(12) Clinical Services
Inpatient Care Units: Pediatrics:
Pediatric Admission
12-3028.1

APPROVED:

Medical Executive Comm.: ~~09/10/14~~

Board Of Directors: ~~09/24/14~~

H. Nursing personnel caring for the child shall read the physician's progress notes to keep abreast of the patient's problems.

I. When pediatric patients are to be placed in a room together, nursing staff shall confer with the physician(s) if there is a question concerning compatible diagnosis.

J. Nursing staff shall start intravenous infusions on children as ordered. IV starts shall be done on a timely basis after admission. After four (4) total attempts (2 attempts, times 2 nurses), if nursing is unable to start the IV, the physician shall be notified as soon as possible.

K. Growth charts shall be used on all Pediatric patient medical records of children under thirteen (13) years of age.

L. Children under the age of three (3) years shall not share rooms with older children.

M. If there are any problems with a child and the attending physician or his/her designee is not available, the Chief of Pediatrics shall be notified.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all other policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Pediatric Admission

Descriptive Type: Revised

Document Number: 12-3028.1

Attachments: None

Author: Patti McCowan

Typist: Melissa Arend

Creation Date: 11/20/08

Revision Date: ~~08/14/14~~4/24/18

Prev. Dist. Date: 01/27/11

Committee Review and Approval:	Approval Date:	Comments:
Pediatrics Committee	N/A~~08/27/14~~	Date change only
MEC	N/A~~09/10/14~~	Date change only
Board of Directors	~~09/24/14~~	

Effective Date: ~~09/25/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Vaccine Informed Consent Requirements

As required under Section 2126 of the Public Health Service Act, effective October 1, 1994, all health care providers who administer any vaccine which is required shall, prior to administration of the vaccine, provide a copy of the relevant vaccine information materials to any adult to whom such provider intends to administer such vaccine, and to the legal representative of any child to whom such provider intends to administer such vaccine. (Legal representative is defined as a parent or other individual who is qualified under state law to consent to the immunization of a minor.) Vaccine information materials are available in several languages. A link to the Vaccine Information Sheets can be accessed from the TLHCD ~~DH~~ Intranet site. This link will give you access to WWW.Immunize.org/vis/index.htm.

A vaccine administration record is provided for patients (or parents/guardians) to sign indicating they have read the information and request immunization. It is legally required that, for each dose of the vaccines administered, providers record and retain the following information in the hospital's permanent medical record on the patient including: Hospital address, date vaccine administered, vaccine manufacturer, vaccine lot number, site of injection, and the signature and title of the vaccine administrator.

Information must be given to all adults receiving immunization and to the legal guardian of all children receiving immunization. Informed consent must be given to each separate administration, even if immunizations are the same vaccine given in a series. Because of the possibility of changes in the information contained within the vaccine information materials between the time a series of immunizations is begun until it is completed, the most recent copy of the materials must be given to vaccine recipients prior to the administration of each vaccine.

If the patient experiences an adverse event to the vaccine, the patient/parent/guardian may report the adverse reaction to their physician/clinic/hospital or VAERS directly as instructed on the vaccine information material. Completion of the VAERS-1 form and reporting of the adverse event (as detailed in the Vaccine Injury Table) shall be processed as described in the Vaccine Adverse Event Reporting System (VAERS) flow chart. There are three ways to report to VAERS:

Effective Date: ~~04/28/11~~	(12)	Clinical Services Inpatient Unit Services: Vaccine Informed Consent Requirements 12-3032
Approved:		
Medical Executive Comm.: ~~04/13/11~~		
Board of Directors: ~~04/27/11~~		

1. Online via a secure website at Https://secure.vaers.org/VaersDataEntryintro.htm
2. Fax a completed VAERS form to 877-721-0366
3. Mail a completed VAERS form to VAERS, P.O. Box 1100, Rockville, MD 20849-1100

Each patient care unit, including the Emergency Department and Home Care shall have a supply of vaccine information materials, vaccine consent forms, and reporting instructions relevant to vaccine administration for that unit. Consents are available through Materials Management.

Consents (see attached) for administration of all vaccines must be signed by the patient and/or legal guardian, including flu and pneumonia vaccines. Information regarding the Flu vaccine is updated as needed due to the changes made to the vaccines.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE REGIONAL MEDICAL CENTER

CONSENT TO RECEIVE VACCINE

Your signature below indicates that:

1. You have received a copy of the Centers for Disease Control Vaccination Information Statement checked below; each includes the risks and benefits of receiving the vaccine.

   ☐ (Pneumonia Vaccine) Pneumococcal Polysaccharide Vaccine (PPV23) 7/29/07
   ☐ (Flu Vaccine) Inactivated Influenza Vaccine 7/16/07
   ☐ Tetanus/Diphtheria (td) 06/10/94
   ☐ Measles, Mumps, Rubella (MMR) 11/15/03
   ☐ Hepatitis B 7/18/07
   ☐ Diphtheria, tetanus, and pertussis (DTaP) 07/12/06
   ☐ Other _____
   List Vaccine information Statement given to patient Date of published Vis

2. You have had the opportunity to discuss this matter with your physician

3. Your agreement to receive the above indicated vaccine:

_____ _____/_____a.m./p.m.
Signature [patient/parent/conservator/guardian *Date* *Time*

_____ _____
Relationship [if signed by other than patient] *Witness*

WHITE: CHART COPY **YELLOW: PATIENTS COPY** **20250 REV. 12/07**

TULARE REGIONAL MEDICAL CENTER

EI CONSENTIMIENTO para RECIBIR VACUNA

Su firma al calce indica que:

1. Usted ha recibido una copia de los Centros para la Declaración de Información de Vacunación de Control de Enfermedad verificó abajo; cada incluye los riesgos y los beneficios de recibir la vacuna.

   ☐ Vacuna Neumocócica Polisacarida, Vacuna de Neumonía) PPV23) 7/29/07
   ☐ Vacuna Contra La Gripe Desactivada 7/16/07
   ☐ Vacuna Contra Tétanos Y Difteria (td) 6/10/94
   ☐ Vacuna Contra Sarampion, Y Paperas Y Rubéola (MMR) 11/15/03
   ☐ La Vacuna Contra La Hepatitis B 7/1/07
   ☐ Vacuna Contra Tétanos, Difteria Y Tos Ferina (Tdap) 7/12/07
   ☐ Lista Otro _____ _____
   Lista de la Declaración de Vacuna que recibió *Fecha Vacuna que recibió*

2. Usted ha tenido la oportunidad de conversar sobre este asunto con su médico, incluyendo la donación por adelantado.

3. Su acuerdo para recibir el encima de vacuna indicada.

_____ _____/_____a.m./p.m.
Firma (paciente/padre/madre/conservador/tutor) *Fecha* *Hora*

_____ _____
En caso de firmarse por una persona que no sea el *Testigo [Witness] paciente, indique la relación*

Descriptive Name: Vaccine Informed Consent Requirements

Descriptive Type: Revised

Document Number: 12-3032

Attachments: Yes – 2 Consent Forms

Author: ~~Melissa Janes / Shawn Elkin/~~ Melissa Janes/Shawn/Elkin

Typist: ~~Delicia Dimberg~~Andrea Carrasco/Ena Menezes

Creation Date: 11/18/00

Revision Date: 01/23/18

Prev. Dist. Date: 04/24/08

Committee Review and Approval:	Approval Date:	Comments:
Infection Control	~~01/25/11~~	
P&T Committee	~~04/06/11~~	
MEC	~~04/13/11~~	
Board of Directors	~~04/27/11~~	

Effective Date: ~~04/28/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Medical Records

FROM: Administration

SUBJECT: Tissue Specimens Excluded From Surgery Service Committee Review

It has been determined that certain tissue specimens removed during an operative procedure are considered to be of benign and unremarkable nature. It is policy of the TRMC ~~DH~~ Medical Staff that the following tissues shall be excluded from review by the Surgery Service Committee:

Hernia Sacs (Adults)	Orthopedic Hardware
Cataracts	Foreskins (Infants)
Scars	

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
(Tulare District HealthCare System) (TDHS)

POLICY/GUIDELINE MANUAL

12-3039

Board of Directors: ~~04/22/09~~

Descriptive Name:	Tissue Specimens Excluded From Surgery Service Committee Review
Descriptive Type:	Revised
Document Number:	12-3039
Attachments:	None
Author:	~~Virginia Wentworth~~Ena Menezes/Andrea Carrasco
Typist:	~~Julie Gresham~~Andrea Carrasco
Creation Date:	01/01/04
Prev. Dist. Date:	5/25/06

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~03/18/09~~	
MEC	~~04/08/09~~	
Board of Directors	~~04/22/09~~	

Effective Date:	~~04/23/09~~
Forward To:	Policy Binders (PBX and Administration) and post to Intranet
Disposition:	Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Physicians' Order Process for Same Day Surgery

POLICY:

1. To facilitate an expedient and efficient admissions process for inpatients and outpatients who are having same day surgery.

2. To eliminate delays in the surgery schedule which have been caused by inconsistencies in the physicians' order process.

3. To eliminate inconvenience and expense to the patient by detecting abnormalities on the testing values prior to the patient's admission to the hospital.

PROCEDURE FOR THE ADMISSION OF A PATIENT FOR ELECTIVE SURGERY:

1. To expedite the process it is recommended that the patient complete the Pre-admission process 2-3 days prior to the scheduled surgery by calling the number on the Pre-assess testing form for an appointment.

2. The patient should receive instructions to remain NPO after midnight, or according to the physician's orders, on the day of surgery, especially if he/she is having general anesthesia, lab work, EKG and X-ray.

3. All orders, including lab tests, shall be written on the Physicians' Order Form (available from Materials Management) or in the electronic medical record. This order ~~form~~ will be used as a "check-off" list, by all hospital departments, as each order is carried out.

   a. The EXACT surgical procedure, that is to be performed, shall be written legibly on the Physicians Order Form or in the electronic medical record. The surgical consent will be typed in the Admissions Office based on what is written on the order form.

Effective Date: ~~03/31/11~~

Approved:

Medical Executive Comm.: ~~03/09/11~~

Board of Directors: ~~03/30/11~~

(12) Clinical Services
Inpatient Care Units:
Physicians' Order Process
For Same Day Surgery
12-3040

4. All orders are to be in the Admissions Office prior to the pre-admission or be sent with the patient during the pre-admission process.

    a. The patient shall be instructed to go to the Admissions Office and present the Admissions Representative with the orders, the History and Physical (if done) and any consents mandated for the operation to be performed. The admissions process will be completed at this time.

    b. The Pre-admit Nurse or designee will inform the physician if the necessary forms are incomplete or missing. The physician is responsible to deliver the forms, including the History and Physical prior to the admission of the patient on the day of surgery.

    c. The Admissions Representative shall direct the patient through the testing areas (Radiology, Lab and EKG). Indication for chest X-ray (CXR) shall be stipulated when ordered by the physician. Further physician orders will be given to the patient to follow on the night before surgery.

5. When diagnostic tests are ordered, there must be sufficient time to have the tests interpreted and placed on the patient's chart so that the results shall be available for the anesthesiologist at the time the patient is admitted to the hospital for surgery.

    a. This process will enable the Pre-admit Nurse or designee to compile and review all the testing results and notify the physician of any abnormalities on the day prior to surgery during routine office hours, thereby allowing time for follow-up, or changes in the schedule.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Physicians' Order Process for Same Day Surgery

Descriptive Type: Revised

Document Number: 12-3040

Attachments: None

Author: Andrea White/Andrea Carrasco/Ena Menezes

Typist: ~~Julie Gresham~~Andrea Carrasco

Revision Date: 01/23/18

Creation Date: 06/10/08

Prev. Dist. Date: ~~07/24/08~~

Committee Review:	Approval Date:	Comments:
Surgery Committee	~~02/16/11~~	
MEC	~~03/09/11~~	
Board of Directors	~~03/30/11~~	

Effective Date: ~~03/31/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Withholding Life Sustaining Procedures and Do Not Resuscitate (DNR)

To establish and clarify Hospital/Medical Staff policy concerning a "NO CODE BLUE/DO NOT RESUSCITATE", the following policy is effected:

A. DO NOT RESUSCITATE (DNR)

Per Hospital policy (#21-2002, "Code Blue/White: Cardiopulmonary Resuscitation"), a CODE response is indicated for any patient experiencing cardiac arrest, and/or absent or agonal respirations." This CODE response utilizes Advanced Cardiac Life Support guidelines to provide an organized, integrated, emergency response that includes CPR, ventilator support, and medication therapy.

A CODE is unique among therapeutic modalities in that it is initiated without a physician's order, according to current American Heart Association, ACLS guidelines, when cardiac or respiratory arrest is recognized. It is implemented in full when indicated, unless there is a DNR order in effect for the patient. Any “Partial Code” Order Must Clearly Specify the Resuscitation Measures To Be Eliminated. In some circumstances, some but not all cardiopulmonary resuscitative measures may be appropriate for a particular patient. For example, routine intravenous antiarrhythmic medications may be determined to be appropriate for the patient while the relative benefits and burdens of chest compressions or intubation may indicate these treatments are not appropriate. A physician who wishes to eliminate some but not all of the routinely implemented resuscitative measures must clearly specify on the order sheet those measures which are to be withheld. Those measures not explicitly designated to be withheld shall be implemented in accordance with the Hospital’s protocol for cardiopulmonary resuscitation.
The patient, or if possible under the circumstances, the patient's nearest available relative(s), shall be consulted about their wishes regarding resuscitation. If the patient is under guardianship or conservatorship, the patient's guardian or conservator shall be consulted.

The following should be considered when deciding on a DO NOT RESUSCITATE ORDER:

1. If patient is competent, honor patient's wishes.

2. If the patient has an Advance Directive stating the wishes of no resuscitative (code) measures. See Hospital Policy 10-1096 Advance Care Planning and Advance Directive Policy.

3. If patient is unable to understand condition or express wishes, establish likelihood of reversing illness.

4. If illness irreversible, a do not resuscitate order may be considered. Discuss decision with other physicians with expertise in establishing prognosis.

5. Discuss decision with family if possible. If primary physician, consulting physician, and family agree, the patient and/or family should sign the form expressing their wish that no resuscitative (CODE) measures be carried out. The form recommended by the California Hospital Association titled "Physician Orders for Life-Sustaining Treatment (POLST) can be found in the CAHHS Consent Manual or at*: **www.finalchoices.org**.* If this step is taken, the physician must initiate a DO NOT RESUSCITATE ORDER on the physician's order sheet. See Hospital Policy 12-1047 Physician Orders for Life-Sustaining Treatment (POLST).

6. If a strong disagreement persists, the Ethics Committee may be helpful in reaching a decision. The Committee's recommendation is advisory; the attending physician is ultimately responsible for making the treatment decision. If continued disagreement occurs then the hospital Administrator should be contacted to determine whether court authorization should be sought.

The following procedures shall be followed to implement a decision not to resuscitate:

1. In the progress notes, the physician documents the factors considered in the decision and the content of discussions with family and consultants.

2. A DNR order must be written on the patient's chart on the physician's order sheet. Telephone DNR orders shall be accepted only in an emergency. All DNR orders shall be countersigned by the ordering physician within twenty-four (24) hours.

3. The Hospital shall explain to patients, families and to patient representatives, if applicable that unless directed otherwise, suspension of Advance Directives occurs during an operation, in the recovery room, and during procedures that

require medications or sedation. If a patient or patient representative objects to the suspension of an Advance Directive under these circumstances, the patient or representative shall be referred to the attending physician to discuss this policy. Continuing disagreements relating to suspension of Advance Directives may be referred to the Ethics Committee. The terms of a valid Advance Directive shall be followed and shall not be suspended, if the patient or patient representative objects.

4. Discuss decision and the reasons for it with all staff involved in the care of the patient.

5. Continue appropriate medical therapy and comfort measures.

   a. Do Not Resuscitate orders remain in effect from the time of writing unless cancelled.

B. DEFINITIONS

1. Surrogate Decision Makers

When a patient is incapable of making a decision regarding the use of life-sustaining procedures because of his medical condition or for other reasons, a surrogate decision-maker should be consulted.

   a. Standards for All Surrogates Decision Makers

      (1) Patient's Desires

A patient's surrogate, whether court appointed or not, must be guided first by his knowledge of the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent. This may include any knowledge of the patient's expressed values on life and how it should be lived as well as the patient's attitudes towards sickness and suffering.

      (2) Patient's Best Interest

If the patient's desires are unknown, the surrogate is to be guided by the patient's best interests such as the relief of suffering, the preservation or restoration of functioning, the quality as well as the extent of life sustained and the impact of the decision on those people closest to the patient may be considered.

b. Selecting Surrogate Decision Makers

In determining who should act on behalf of an incompetent patient, the general principles regarding who may give consent shall be applied. Thus, an attorney-in-fact designated by a patient in a Durable Power of Attorney for Health Care, conservators, and parents or guardians shall be consulted. Refer to the CAHHS Consent Manual, Chapter 2, Section 2.

2. Consultation with the Patient's Family and Significant Others

The patient's family and significant others shall be consulted whenever possible, even if a competent patient or his legal representative has authorized termination of life-sustaining treatment. Family members and significant others who disagree can then be given an opportunity to discuss their concerns with the patient or the legal representative and attempt to influence his decision.

a. Definition of "Family"

There is no established precedent as to who should be considered to constitute the patient's "family" and "significant others"; therefore, the physician should generally consult with those relatives and others who appear to be close to the patient and who have expressed an interest in the patient by visiting him or consulting with his physician and hospital staff. In addition, it is advisable to consult with any other close relatives, such as spouse, children, or parents, competent and available (e.g. can be contacted by phone), whenever possible, in identifying who should be consulted. However, if the patient is incompetent, the relatives and friends who have been involved should be asked if there are others who should be consulted about the proposed decision.

Please refer to CAHHS Consent Manual, Chapter 5, Section 5.3Appendix 5-A, Guidelines for Withholding and Withdrawing Life Sustaining Treatment and Chapter 2, Who May Give Consent
Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Exhibit A

Introduction to the POLST Form

POLST is a physician order that gives patients more control over their end-of-life care. Produced on a distinctive bright pink form and signed by both the physician and patient, POLST specifies the types of medical treatment that a patient wishes to receive towards the end of life. In order to maintain continuity throughout California, please follow these printing instructions:

***** Copy or print POLST form on 65# Cover Pulsar Pink card stock. *****

Wausau Pulsar Pink card stock is available online and at some office supply stores. Pulsar pink paper is used to distinguish the form from other forms in the patient's record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms. POLST forms and Pulsar Pink paper may be purchased in bulk from Med-Pass, www.medpass.com.

For questions, email info@finalchoices.org or call (916) 489-2222. To learn more about POLST, visit www.caPOLST.org.

FORMS ARE AVAILABLE ON-LINE IN VARIOUS LANGUAGES.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2009)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name	
First /Middle Name	
Date of Birth	Date Form Prepared

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***Person has no pulse and is not breathing.***

☐ **Attempt Resuscitation/CPR** **(Section B: Full Treatment required)** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in **B** and **C**.

B *Check One*

MEDICAL INTERVENTIONS: ***Person has pulse and/or is breathing.***

☐ **Comfort Measures Only** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Antibiotics only to promote comfort. ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Do Not Transfer to hospital for medical interventions. Transfer*** if comfort needs cannot be met in current location.

☐ **Full Treatment** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. ***Transfer*** *to hospital if indicated. Includes intensive care.*

Additional Orders: _____

_____

C *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: ***Offer food by mouth if feasible and desired.***

☐ No artificial nutrition by tube. ☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

Additional Orders: _____

D

SIGNATURES AND SUMMARY OF MEDICAL CONDITION:

Discussed with:

☐ Patient ☐ Health Care Decisionmaker ☐ Parent of Minor ☐ Court Appointed Conservator ☐ Other:

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name	Physician Phone Number	Date
Physician Signature (required)	Physician License #	

Signature of Patient, Decisionmaker, Parent of Minor or Conservator

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (required)	Name (print)	Relationship (write self if patient)
Summary of Medical Condition	Office Use Only	

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Patient Name (last, first, middle)	Date of Birth	Gender: M F
Patient Address		

Contact Information

Health Care Decisionmaker	Address		Phone Number
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professional

Completing POLST

- Must be completed by health care professional based on patient preferences and medical indications.
- POLST must be signed by a physician and the patient/decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- Certain medical conditions or medical treatments may prohibit a person from residing in a residential care facility for the elderly.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- Treatment of dehydration prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The person is transferred from one care setting or care level to another, or
- There is a substantial change in the person's health status, or
- The person's treatment preferences change.

Modifying and Voiding POLST

- A person with capacity can, at any time, void the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or a new POLST form.
- To void POLST, draw a line through Sections A through D and write "VOID" in large letters. Sign and date this line.
- A health care decisionmaker may request to modify the orders based on the known desires of the individual or, if unknown, the individual's best interests.

California Coalition for Compassionate Care

The Coalition is the lead agency for implementation of POLST in California. This form is approved by the Emergency Medical Services Authority in cooperation with the California Coalition for Compassionate Care and the statewide POLST Task Force.

For more information or a copy of the form, visit **www.finalchoices.org**.

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Descriptive Name: Withholding Life Sustaining Procedures and Do Not Resuscitate (DNR)

Descriptive Type: Revised

Document Number: 12-3046

Attachments: POLST Form

Author: Carol Bradford

Typist: Julie Gresham/Gillian Busch

Creation Date: 04/14/10

Revised Date: 4/24/18

Prev. Dist. Date: 05/26/05

Committee Review and Approval:	Approval Date:	Comments:
Code Blue Committee	N/A~~07/22/10~~	Date change only
Cardiac Cath Lab/ICU Committee	N/A~~05/16/11~~	Date change only
MEC	N/A~~08/10/11~~	Date change only
Board of Directors	~~08/24/11~~	

Effective Date: ~~08/25/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Pharmacy, Clinical Services, and Medical Records

FROM: Administration

SUBJECT: Emergency Department Holding Orders

This policy is established to facilitate holding orders written by the Emergency Physician are current and consistent with the attending Physician's treatment.

1. Emergency Department Physicians may write holding orders in concurrence with the admitting physician.

2. All orders written by the Emergency Physician shall expire eight (8) hours, except for critical care patient's (as per Medical Staff Bylaws/Rules) after the patient is admitted.

3. Emergency Department Physician's are encouraged to use printed Physician order #094 – "Emergency Department Physicians Initial Admitting Orders" to facilitate admission process of ED patient's.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Emergency Department Holding Orders

Descriptive Type: Revised Policy

Document Number: 12-3048

Attachments: None

Author: Martha Heavrin

Typist: Hillary Keith

Creation Date: 1/31/08

Revised Date: 4/24/18

Prev. Dist. Date: 07/29/04

Committee Review and Approval:	Approval Date:	Comments:
E&O	N/A~~10/01/08~~	Date change only
MEC	N/A~~10/15/08~~	Date change only
Board of Directors	~~10/22/08~~	

Effective Date: ~~10/23/08~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Emergency Vaginal Birth after a Previous Cesarean Delivery (VBAC)

Policy:

Unsuccessful VBAC's are associated with a small but significant risk of uterine rupture with poor outcome for both mother and infant. VBAC candidates **are not** selected or scheduled at Tulare Regional Medical Center. In the event that a woman with a previous history of cesarean section presents with delivery eminent, serious efforts will be made to manage the intrapartum course per ACOG guidelines for a VBAC delivery.

Purpose:

Establish guidelines for appropriate management of a VBAC delivery

I. Contraindications
   A. Previous classical uterine incision or unknown scar
   B. Macrosomia
   C. Gestation greater than 40 weeks
   D. Multiple gestation
   E. Absolute cephaolopelvic disproprotion

II. Intrapartum Management:
   A. Obtain patient's signature on "Refusal to have Cesarean Section After Previous Cesarean Section" form.
   B. Obtain consent for VBAC
   C. Obtain obstetrical consultation.
   D. Establish intravenous access.
   E. Labs: at minimum, CBC, urinalysis, blood type & screen.
   F. Continuous Fetal Monitoring
   G. Personnel immediately available (mandatory):
      1. Physician capable of performing emergency cesarean.
      2. Anesthesia provider
      3. Operating room personnel
      4. Physician capable of attending the newborn.

Board of Directors:

H. It shall be the responsibility of the attending physician to determine whether these guidelines can be met (including availability of an anesthesiologist and a surgery crew) in determining whether to allow his patient to proceed with a trial of labor and his evaluation shall be ongoing throughout the course of the labor.

I. There shall be clear documentation by the physician detailing the risks and benefits discussed as well as findings of frequent and serial assessments.

J. Augmentation of labor: (note: the use of prostaglandins for induction of labor is contraindicated).

1. Oxytocin as per protocol (note: use of oxytocin increases the risk of uterine rupture from 0.4% to 1%: ACOG Practice Bulletin July 2004).

2. Any arrest disorder in the presence of adequate labor requires prompt intervention and cesarean delivery

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

REFUSAL TO HAVE CESAREAN SECTION AFTER PREVIOUS CESAREAN SECTION

Note to the Patient: As you may know, there are risks in any medical, surgical procedure or treatment. Because Tulare Regional Medical Center and your physician do not routinely perform VBAC and because we do not have an Anesthesiologist and a surgery crew present at the hospital 24 hours a day, the following list is designed to help you to understand the risks of refusal to have a cesarean section and your decision to proceed with Vaginal Birth After Cesarean Section (VBAC). Please discuss the contents of this form with your physician.

1. I understand that I have had one or more prior cesareans(s).
2. I understand that the risk of uterine rupture during VBAC in someone like me who has had a prior incision in the noncontracting part of my uterus is around 1%
3. I understand that VBAC is associated with a higher risk of harm to my baby than to me.
4. If my uterus ruptures during my VBAC, I understand there may not be sufficient time to operate and prevent death or permanent brain injury to my baby.
5. The exact frequency of death or permanent neurologic injury to the baby when the uterus ruptures is uncertain, but has been reported to be as high as 50%.
6. The risks to me after rupture of the uterus include, but are not limited to, hysterectomy (loss of the uterus), blood transfusion, infection, injury to internal organs, (bowel, bladder, ureter), blood coagulation problems or death.
7. I understand that if I attempt a VBAC and end up having a cesarean during labor, I have a greater risk or problems than if I had simply elected a repeat cesarean. Risks are as specified in the consent for cesarean section.
8. I understand that Tulare Regional Medical Center staffs the Operating Room with an Anesthesiologist and a surgery crew from 8:00 A.M. to 5:00 PM and that at all other times the anesthesiologist and surgery crew are on call. There can be a delay from the decision to do surgery until the surgery is started while the Anesthesiologist and the surgery crew are called in. I also understand that if the Anesthesiologist and the surgery crew have already been called in for another emergency surgery that my surgery could be delayed.

I hereby acknowledge that my attending physician, Dr._____ has informed me of the nature and advisability of, the risks and complications of, and the probable consequences of not receiving a repeat cesarean section in lieu of a VBAC.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent contractors.

I have read or have had read to me the above information and I understand it. I have discussed my options with my doctor. I have had all my questions answered and I have received all the information I need to make an informed choice. Notwithstanding the recommendations of my attending physician, I hereby request that a repeat cesarean section not be administered to me during my stay at Tulare Regional Medical Center and hereby release the hospital, its personnel, my attending physician and any other persons participating in my care from any responsibility whatsoever for unfavorable or untoward results which I understand may occur as a result of my refusal to permit this repeat cesarean section.

Signature_____ Date_____ Time _____
If signed by other than patient, indicate relationship_____
(patient/parent/conservator/guardian)
Witness_____

Physician Signature _____ ____Date_____Time_____

Descriptive Name: Emergency Vaginal Birth after a Previous Cesarean Delivery (VBAC)

Descriptive Type: Revised

Document Number: 12-3054

Attachments: Yes (1)

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 08/25/11

Revision Date: 08/24/17

Prev. Dist. Date: 08/26/14

Committee Review and Approval:	Approval Date:	Comments:
OB Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Respiratory Services and Clinical Services

FROM: Administration

SUBJECT: Oxygen Administration in the Nursery

I. PURPOSE:

In order to comply with Title 22 and the ~~Joint Commission~~DNV recommendations, the following policy is established for the administration of oxygen in the nursery.

II. POLICY:

A. Administration of oxygen in the Nursery shall at all times be initiated under the orders of a physician. An exception shall be made in an emergent situation while attempting to contact the physician. O_2 shall be administered at a percentage and/or L/min required to maintain the oxygen saturation between 93% and 96% or as specified by attending physician.

B. All physician orders for oxygen must include an initial oxygen concentration.

C. All orders for oxygen must include the method of delivery (such as oxyhood, free flow mask, etc.,).

D. When a physician orders oxygen on an infant, blood oxygen concentration must be monitored by ABG, capillary blood gases, or pulse oximetry.

E. All documentation of oxygen administered shall be recorded in fractional inspired oxygen (FIO_2 percentage) at 2 hour intervals.

F. The 0_2 saturation should be maintained between 93% and 96%. Parameters will be specified in the physician's orders. With any increase in oxygen concentration of 10% or more above the physician's initial order, or over 40% $Fi0_2$, the physician shall be notified. The physician shall review and document the need for oxygen daily.

Effective Date:

APPROVED:

Medical Executive Comm.:

Board Of Directors:

(12) Clinical Services
Inpatient Care Units:
Oxygen Administration in the Nursery
12-3056

G. The FiO_2 may be adjusted for short periods during stressful procedures (lab, X-Ray, suctioning, etc.). Such adjustments and the reason for them shall be documented in the nurse's notes.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Oxygen Administration in the Nursery

Descriptive Type: Revised

Document Number: 12-3056

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 04/24/08

Revision Date: 08/24/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatrics Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff & Clinical Services

FROM: Administration

SUBJECT: Newborn Exam Policy

In an effort to maintain the standards of care established by the TRMC Medical Staff, the following policy is affected:

1. All newborn babies shall have a complete physical examination by a physician **within twenty-four (24) hours** of birth.

2. All newborn babies shall be examined the day of or the previous day of discharge.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: (12) Clinical Services
Inpatient Care Units:
APPROVED: Newborn Exam Policy
12-3057

Medical Executive Comm.:

Board Of Directors:

Descriptive Name: Newborn Exam Policy

Descriptive Type: Revised

Document Number: 12-3057

Attachments: None

Author: Patti McCowan

Typist: Melissa Arend

Creation Date: 05/29/08

Revision Date: 08/24/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatrics Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: OB-GYN and Pediatric Physicians

FROM: Administration

SUBJECT: Pediatrician or Other Qualified Physician Presence During High Risk Deliveries

In order to insure appropriate and timely medical care for the newborn, whenever there is an indication of fetal distress or gestational age of less than 35 weeks or any complicated pregnancy, the physician performing the vaginal delivery or cesarean section delivery shall insure that a Pediatrician or other qualified physician of similar competency is notified.

Any physician interested in standing in on Cesarean section and high-risk deliveries must provide proof he/she is currently certified in PALS or NRP including intubation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date:

APPROVED:

Medical Executive Comm.:

Board Of Directors:

(12) Clinical Services
Inpatient Care Units:
Pediatrician or Other Qualified Physician Presence During High Risk Deliveries
12-3058

Descriptive Name: Pediatrician or Other Qualified Physician Presence During High Risk Deliveries

Descriptive Type: Revised

Document Number: 12-3058

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 04/24/08

Revision Date: 08/24/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatric Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Active Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Protocol for Antenatal Hepatitis Screening of Expectant Mothers

1. Screening for HBsAg shall be done prenatally on all mothers.

2. Positive results shall be documented on the prenatal record so the infant can be immediately treated.

3. The Health Department will be notified when a newborn is started on Hepatitis B prophylaxis in the hospital for further follow-up after discharge. They will be notified of mother's HBsAg antigen test results. The results will be recorded in both the mother's and the baby' charts.

4. If ordered by the Physician, follow the Hepatitis-B Protocol for Newborns (Physician's Order #616 – see attached).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Date: _____
Time: _____

HEPATITIIS-B PROTOCOL FOR NEWBORNS

IF MOTHER IS KNOWN HEPATITIS-B POSITIVE:

- ☐ Within 12 hours of birth give Hepatitis B Immune Globulin (HBIG) in thigh (do not give for newborns < 2 kg).
- ☐ Within 12 hours of birth give initial dose of Hepatitis-B Pediatric Vaccine concurrently with HBIG at a different site (contralateral thigh) (do not give for newborns < 2 kg).

IF MOTHER IS UNKNOWN HEPATITIS-B STATUS:

- ☐ If mother states she has had previous lab work done, call physician's office or lab to get results.
- ☐ If mother has not been tested, or if results are not available from lab or physician's office within 12 hours of baby's birth:
  - ☐ Utilize standing order from mother's physician to order Hepatitis-B screen on mother
- ☐ Give initial dose of Hepatitis-B Pediatric Vaccine 0.5ml IM in thigh (do not give for newborns < 2 kg).
- ☐ If the mother is then found to be HBsAg-Positive, the infant should receive HBIG 0.5ml IM in thigh within 7 days of birth or before discharge, whichever comes first. If the mother's HBsAg results are not known at time of discharge, administer HBIG 0.5ml IM before discharge of baby.

IMMUNIZATION DOCUMENTATION:

- ☐ Have mother sign vaccine consent form prior to vaccination.
- ☐ Complete State of California Immunization Record (CVIS) when vaccine administered and give immunization record to mother.
- ☐ Other _____

LAB:

- ☐ Other _____
- ☐ Other _____

IMAGING:

- ☐ Other _____ **Indication:**_____
- ☐ Other _____ **Indication:**_____

RESPIRATORY:

- ☐ Other _____
- ☐ Other _____

MEDICATIONS:

- ☐ Hepatitis B Immune Globulin (HBIG) 0.5ml IM in thigh
- ☐ Hepatitis-B Pediatric Vaccine 0.5ml IM in contralateral thigh (do not give to Newborn < 2 kg).
- ☐ Other _____

OTHER ORDERS:

- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

PHYORD 616 (CPOE)

_____
Physician Signature

Descriptive Name: Protocol for Antenatal Hepatitis Screening of Expectant Mothers

Descriptive Type: Revised

Document Number: 12-3067

Attachments: Hepatitis-B Protocol for Newborns

Author: Patti McCowan

Typist: Julie Gresham

Creation Date: 07/01/14

Revised Date: 4/24/18

Prev. Dist. Date: 08/25/11

Committee Review and Approval:	Approval Date:	Comments:
OB/Pediatric Committee	N/A~~07/23/14~~	Date change only
MEC	N/A~~08/13/14~~	Date change only
Board of Directors	N/A~~08/25/14~~	

Effective Date: ~~08/26/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Medical Staff and Pharmacy Staff

FROM: Administration

SUBJECT: Pediatric Dosing – Weight-based

I. POLICY

It is the policy of Tulare Regional Medical Center to require weight-based dosing for antibiotics for pediatric patients. The Physician may also include weight-based dosing for other medications as he/she feels is appropriate. For the purpose of medication dosing, pediatric patients are defined as those patients whose age limit is from birth to 13 years of age. It is understood that a patient younger or older than 13 years of age may require weight-based dosing requirements dependent upon his or her individual physical level of growth and development. Physicians may opt to use normal adult dosing on children under the age of 13, once the patient's weight has extended the dose beyond pediatric dosing parameters.

II. PROCEDURE

The following procedure/guideline should be followed for weight-based pediatric dosing:

A. All pediatric antibiotic medications must include the patient's current weight listed in kilograms (kg) and body surface area (BSA) if applicable.

B. The order must include the dose (in mg or mEq as applicable) of the medication, the weight-based dosing (i.e. mg/kg, etc.) utilized to calculate the medication regimen and the patient's current weight in kilograms.

C. Any pediatric medication orders that do not specify the patient's weight will be considered incomplete and will not be prepared, dispensed or administered.

Effective Date: ~~06/26/14~~ (12) Clinical Services
Inpatient Care Units:

APPROVED:

Pediatric Dosing – Weight-based

12-3070

Medical Executive Comm.: ~~06/11/14~~

Board of Directors: ~~06/25/14~~

The Pharmacist or other licensed care provider will contact the prescriber to clarify the medication order.

D. The clarified order which includes the patient's weight and dosing parameters will then be documented in the patient medical record by the person clarifying the order.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Pediatric Dosing – Weight-based

Descriptive Type: Revised Policy

Document Number: 12-3070

Attachments: None

Author: Mimi Clayton, Pharmacy Director

Typist: Julie Gresham

Creation Date: 02/04/09

Revised Date: ~~04/30/14~~4/24/18

Prev. Dist. Date: 03/26/09

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	N/A ~~05/05/14~~	Date change only
OB/Pediatric Committee	N/A~~05/21/14~~	Date change only
MEC	N/A~~06/11/14~~	Date change only
Board of Directors	~~06/25/14~~	

Effective Date: ~~06/26/14~~

Forward To: Policy Binders (PBX and Administration) and Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services, and Emergency

FROM: Administration

SUBJECT: Physician Attendance for High Risk Infant Stabilization Prior to Transfer

I. POLICY:

A. 24 hour pediatric call will be maintained for the Intermediate Care Nursery.

B. The on-call pediatrician shall respond to the Intermediate Care Nursery in accordance with the Medical Staff Rules, Conduct of Call Panel Members, Rule 11.3.1.

C. The pediatrician shall remain present in the immediate area of the Intermediate Care Nursery until the Transport Team has arrived during the following:

1. The neonate is receiving bag / mask or Bag / Endotracheal tube ventilatory assistance.

2. The neonate is hemodynamically unstable, requiring treatment for hypotension.

3. The neonate has a cardiac condition or anomaly that may require use of cardiac medications.

4. Any other condition that the physician deems necessary to stay in attendance of the neonate until the transport team arrives.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date:

APPROVED:

Medical Executive Comm.:

Board Of Directors:

(12) Clinical Services
Inpatient Care Unit:
Physician Attendance for High Risk Infant Stabilization Prior to Transfer
12-3071

Descriptive Name: Physician Attendance for High Risk Infant Stabilization Prior To Transfer

Descriptive Type: Revised

Document Number: 12-3071

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 05/29/08

Revision Date: 08/24/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatrics Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Obstetrics Department, Pharmacy and Medical Staff

FROM: Administration

DELETE

SUBJECT: Maternal Group B Streptococcus (GBS)

PURPOSE:

To provide necessary treatment for GBS in order to prevent infection and/or exposure to the neonate.

STANDARD OF CARE:

All expectant mothers will be screened for Group B Streptococcus prenatally. The results shall be documented on the prenatal record.

STANDARD OF PRACTICE:

All patients will receive treatment for Group B Streptococcus according to their history and assessment as set forth by AAP and ACOG guidelines.

POLICY:

1. Clinical personnel will follow the processes and documentation outlined in this procedure.

    A. If patient presents with any of the following risk factors present antibiotic prophylaxis will be started.

        1. Previous infant with invasive GBS disease.
        2. GBS bacteriuria during current pregnancy
        3. Positive GBS screening culture during current pregnancy (Medication not required for planned cesarean section without labor or without rupture of membranes)
        4. Unknown GBS culture (culture not done, incomplete, or results unknown or culture not down within the last five weeks) with any of the following risk factors:
            - Patient is **<37 weeks gestation**.

- Amniotic membranes rupture ≥ 18 hours.
- Intrapartum temperature ≥ 100.4 F
- If patient in preterm labor < 37 weeks and unknown GBS, obtain GBS culture and treat until delivery, preterm labor ceases, or GBS culture results are negative.
- If patient has PPROM (preterm premature rupture of membranes) and unknown GBS, obtain culture, and treat until delivery, or a minimum treatment of 48hrs, if GBS culture comes back negative. (if GBS results are positive-continue to treat)

***If patient is undelivered after treatment and reaches 35-37 weeks, re-culture the patient.

2. Treatment will be as follows:
   A. Ampicillin 2 Grams IVPB upon admit, then 1 Gram IVPB Q 4 hours until delivery.

   B. Penicillin G 5 Million units IVPB upon admit, then 2.5 million units IVPB Q 4 hours until delivery.

   C. Patient's with Penicillin allergies shall be given:

      1. If there is no history of anaphylaxis, angioedema, respiratory distress or urticaria following administration of a penicillin or a cephalosporin, the patient should receive **Cefazolin 2 Grams IVPB upon admit, then 1 Gram IVPB Q 8 hours until delivery.**
      2. Patients at high risk for anaphylaxis, should receive **Clindamycin (900 mg IVPB Q 8 hours until delivery)**, if their GBS isolate is susceptible to clindamycin, AND **Erythromycin,** as determined by antimicrobial susceptibility testing.
      3. Patients at high risk for anaphylaxis should receive **Vancomycin (1 Gram IVPB Q 12 hours until delivery)** if their isolate is resistant to clindamycin as determined by antimicrobial susceptibility testing.

3. DOCUMENTATION:

   A. GBS status (even if unknown) shall be documented on the admit form and delivery record. Treatment will be documented in MAK and nursing notes when appropriate.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Maternal Group B Streptococcus (GBS)

Descriptive Type: DELETE

Document Number: 12-3077

Attachments: None

Author: Patti McCowan

Typist: Melissa Arend

Creation Date: 06/26/08

Revised Date: 06/08/17

Prev. Dist. Date: 05/26/16

Committee Review and Approval:	Approval Date:	Comments:
OB/GYN Committee	06/12/17	DELETE
Pharmacy & Therapeutics Comm.		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments: **This policy has been replaced by policy #12-3080 "Prevention and Treatment of Perinatal Group B Streptococcal Infection"**

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

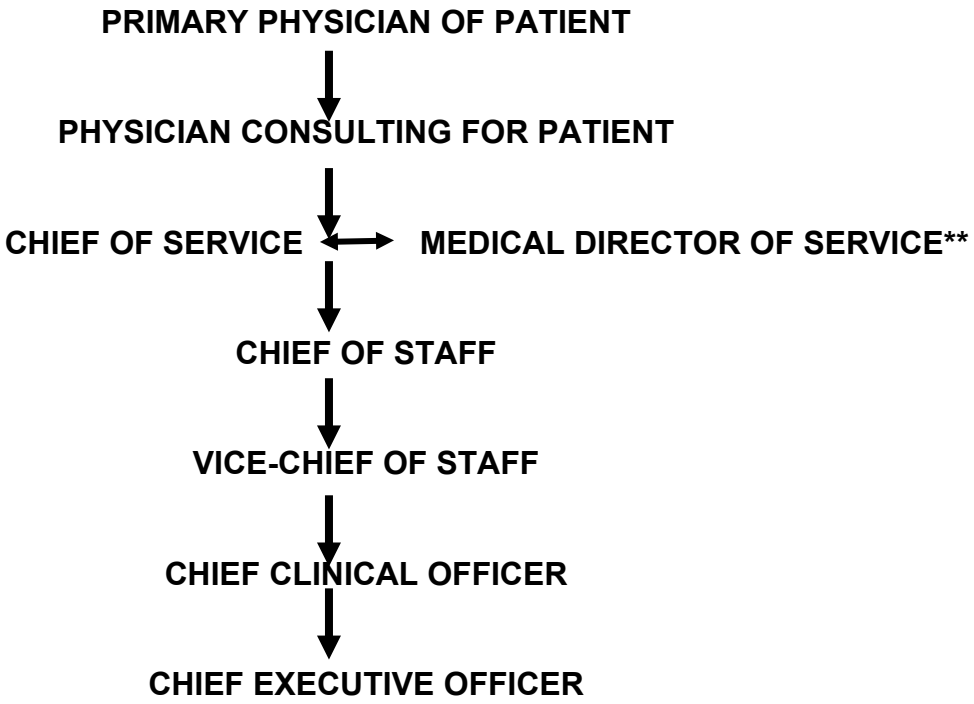
POLICY / GUIDELINE

TO: Clinical Services, Medical Staff

FROM: Administration

SUBJECT: Chain of Command

POLICY:
This policy is established to guide clinical staff in the event the patient's primary care physician cannot be reached within an appropriate time frame.



** Services utilizing a Medical Director: Hospitalist; Intensivist; Emergency Department; Tulare Community Health Clinic; Anesthesiology.

If the Medical Director is the non-responsive physician, the chain moves to the Chief of Staff.

Effective Date: ~~04/25/13~~ (12) Clinical Services
Inpatient Units:
Chain of Command
12-3078

APPROVED:

Medical Executive Comm.: ~~04/10/13~~

Board Of Directors: ~~04/24/13~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Chain of Command

Descriptive Type: Revised Policy

Document Number: 12-3078

Attachments: None

Author: ~~Patricia Mathewson~~Angie Graziano, RN, ~~CCO/~~CNO

Typist: ~~Gillian Busch~~Carol Bradford

Creation Date: 01~~9~~/08~~13~~/18~~2~~

Prev. Dist. Date: 09/25/08

Committee Review and Approval:	Approval Date:	Comments:
Physician/Nursing Patient Care Council	~~11/14/12~~	~~11/14/12 revisions made~~
MEC	~~04/10/13~~	
Board of Directors	~~04/24/13~~	

Effective Date: ~~04/25/13~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: OB Department, Pharmacy, Laboratory and Medical Staff

FROM: Administration

SUBJECT: Post Partum Hemorrhage

I. Purpose:

A. To outline the nursing management for a patient with postpartum hemorrhage in order to provide safe and consistent patient care.

II. Supportive Data:

A. Hemorrhage is defined as a blood loss greater than 500 ml following a vaginal birth or a loss of greater than 1000 ml following a cesarean delivery.

B. Postpartum hemorrhage is classified as primary or secondary. With primary hemorrhage occurring within the first 24 hours of delivery and secondary occurring between 24 hours and 12 weeks postpartum.

III. Risk factors that can lead to post partum hemorrhage are as follows:

Grand multiparity	Malpresentation
Obesity	Uterine Fibroids
Macrosomia	Precipitous Labor
Previous History	Infection
Prolonged Induction	Polyhydramnios
Bicornate Uterus	Multiple Birth
Prolonged Labor	Tocolytics
Operative Delivery	Retained Placenta
HELLP syndrome	Placental abruption
Placenta Previa/Accreta	Post Date Deliveries

IV. Patient Assessment:

A. After delivery the RN must assess per protocol unless patient status indicates more frequent:

Fundal height
Fundal consistency
Fundal location
Lochia
Blood Pressure
Oxygen saturation
Pulse
Respirations
Skin Temperature
Color
LOC

B. Abnormalities Identified: may include but not limited to the following:

Fundus displaced and boggy
Bladder distended
Blood clots
Blood loss – with repeated saturation of pads
Abnormal vital signs: decreased BP, increased pulse, increased respirations
Alteration in LOC
Skin – pallor, cyanosis, clammy
Potential for retained placental fragments

C. If none of the above abnormalities are noted RN is to continue with postpartum assessment per protocol.

V. Interventions:

A. If abnormalities are identified the RN is to implement the following intervention as indicated, but not limited to:

1. Obtain postpartum hemorrhage tool box.
2. Communicate blood loss to obstetrical team
3. Massage fundus and note presence of clots, blood loss, and/or presence of tissue.
4. Measure and record blood loss
5. Notify Physician
6. Keep strict I&O
7. Give 500 IV bolus of LR, consider second IV access
8. Apply Oxygen at 10L/Min via mask
9. Catheterize bladder prn; insert foley catheter if indicated
10. Obtain necessary lab work
11. Prepare for surgical intervention
12. Notify OR

VI. Medications: The following medications should be available to administer per physician order.

Medication	Dose	Route	Frequency	Side Effects	Contraindications
Pitocin	10-40 units in 1000 ml LR or 10 units IM	IV or IM	Continuous infusion	Water intoxication, nausea, vomiting	Hypersensitivity to the medication
Methergine	0.2 mg	IM or PO	2 hours	Nausea, vomiting, hypertension	Hypertension and/or severe preeclamsia/eclampsia, heart disease
Hemabate	250 mcg	IM	Q 15 min (max of 8 doses)	Nausea, vomiting, diarrhea, fever, headaches, hypertension, uterine rupture, chills	Active cardiac, pulmonary (asthma), renal or hepatic disease Hypertension
Cytotec	600-800 mcg	PO or Rectal	Once	Nausea, vomiting, chills, headache	Hypersensitivity to the medication

VII. Documentation:

A. Document using the blood loss worksheet.

B. Document appropriately in Electronic Medical Record. ~~OBIX~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Post Partum Hemorrhage

Descriptive Type: Revised Policy

Document Number: 12-3082

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 09/23/10

Revision Date: 08/23/17

Prev. Dist. Date: 08/26/14

Committee Review and Approval:	Approval Date:	Comments:
OB Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Transport of the Neonate from the Intermediate Care Nursery (ICN) to a Higher Level of Care

I. Purpose:

The purpose of this policy is to provide safe and efficient transport of the newborn from Tulare Regional Medical Center to a higher level of care at another facility. Transfer of the infant should be considered and acted upon when the care provided exceeds the capability of the Intermediate Care Nursery at Tulare Regional Medical Center. Also, parents can request that their infant be transferred to another facility, and in rare situations such as lack of licensed bed space, equipment, or personnel.

II. Policy:

A. All newborns needing a higher level of care than the ICN at Tulare Regional Medical Center can provide, will be transferred to a facility that provides a higher level of care. The Pediatrician will consult with the Neonatologist at a facility that provides a higher level of care to obtain acceptance to the receiving facility.

B. The receiving hospital can decide that they will pick up and transport the newborn utilizing their transport team and equipment.

C. In the event that the receiving hospital cannot pick up and transport the newborn utilizing their transport team and equipment, then those newborns will be transferred by the transport team at Tulare Regional Medical Center, consisting of the Registered Nurse and the Pediatrician, using the ambulance company contracted with the hospital.

D. The Pediatrician will consult with the Neonatologist at the facility that provides the higher level of care to obtain acceptance to the receiving hospital.

III. Equipment:

A. Transport Bag

Effective Date:

APPROVED:

Medical Executive Comm.:

Board Of Directors:

(12) Clinical Services
Inpatient Units:
Transport of the Neonate from the Intermediate Care Nursery (ICN) to a Higher Level of Care.
12-3084

B. Transport Medication Box

C. Syringe Pump

D. Transport Incubator with power pack

E. Oxygen tank

F. Air Tank

G. Suction

H. All necessary paperwork: Transfer forms, ~~Nursing Notes, Physician Order forms, MAR, Physician Progress Notes~~, copy of newborn medical record, copy of pertinent parts of maternal medical record.

IV. Procedure:

A. All infants will be transferred if the capabilities of the ICN cannot meet the needs of the infant. Refer to policy 12-3074 Criteria for Admission to the ICN.

B. The transferring physician must call the receiving hospital's physician and obtain acceptance from the physician to transfer the neonate. At no time is the transferring physician to speak to someone other than the receiving physician.

C. At no time is a staff member of the transferring hospital to obtain acceptance for the transfer.

D. Transport Team: The transport team is composed of a Registered Nurse and a Pediatrician. The transport team is available 24 hours/day 7 days/week.

1. Attending Pediatrician responsibilities:

a. Make the decision to transfer, selecting the mode.

b. Assemble the team and determine what equipment will be necessary.

c. Select the appropriate receiving facility based on the required level of care necessary.

d. Communicate with the receiving facility's physician.

e. Obtain consent for transfer from the family and discuss the risks and benefits of an unstable or critically ill infant.

f. Complete necessary paperwork.

g. Complete orders for transfer.

h. Direct the efforts of the team members.

i. Assure the infant is stabilized to the greatest possible extent, given the clinical condition.

2. Registered Nurse responsibilities:

a. Initiate the transport record.

b. Confirm patient's identity with attending Pediatrician.

c. Prepare the infant for transfer.

d. Collaborate with the receiving facility's charge nurse or designee and give report.

e. Maintain the patient's airway.

f. Assure adequate IV line is in place, if ordered.

g. Offer psychosocial support to the parents and information on how to contact the facility.

h. Perform a pre-transport assessment and document.

i. Open the Transport Bag, assuring all necessary equipment is present and not expired.

j. Pull medications from the Nursery Cart that the Pediatrician wants for the particular transport and place in the Transport Medication Box.

k. Gather and take any documents, blood work, x-rays, etc.

l. While en route, assure the infant is safe and stable, monitoring vital signs and IV fluids per physician orders.

m. Upon arrival to the receiving facility, give report to accepting RN, complete transport record, and give a copy to the receiving hospital.

n. Upon return to Tulare Regional Medical Center, restock the transport bag and return all medications not used to the Nursery Cart.

o. Training of the RN: Must have documented 2 years experience in the ICN, must have NRP, and must be STABLE certified.

3. Transport Coordinator (Department Director or designee) responsibilities:

a. Coordinate any competency training for the team members.

b. Schedule staff members accordingly to assure a competent transport RN is available every shift.

E. The ambulance company that is contracted for transport is Lifestar.

F. The Transport Bag:

1. Stocking of the Transport Bag will be done by the Transport RN upon return from transport.

2. Stocking of the Transport Medication Box will be done just prior to transport.

a. Transport RN will pull all medication from the Nursery Cart that the physician wants for the particular transport.

b. Upon return from transport, the Transport RN will return any medications that are not used.

1. ICN staff will check the Transport Bag on a daily basis and sign the nursery checklist ensuring that the supplies are present and not expired.

2. Equipment to be kept in the Transport Bag:

i. Stethoscope

ii. IV supplies

iii. Suction catheters

iv. Intubation Box

v. Bag and mask resuscitation equipment

vi. Warming mattress

vii. Empty Medication Box

E. The pediatrician on-call will be the physician to accompany the patient during transport.

1. The on-call Pediatrician will make arrangements with another Pediatrician to be available for the hospital until the physician returns from the transport.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Transport of the Neonate from the Intermediate Care Nursery (ICN) to a Higher Level of Care

Descriptive Type: Revised

Document Number: 12-3084

Attachments: None

Author: Linda Callanan

Typist: Melissa Arend

Creation Date: 03/15/11

Revision Date: 08/23/17

Prev. Dist. Date: 09/25/14

Committee Review and Approval:	Approval Date:	Comments:
Pediatric Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Obstetrical Departments

FROM: Administration

SUBJECT: Magnesium Sulfate in Pregnancy - HTN/ Preeclampsia Care Guidelines

POLICY: A physician order which includes medication dosage, route, and lab work (Magnesium levels ordered by physician every 6-8 hours) will be obtained. Safety precautions, vital signs, and deep tendon reflexes will be assessed as outlined under prescribed action.

PURPOSE: To decrease CNS irritability, thereby decreasing: (1) Smooth muscle contractility and/or uterine irritability (2) The risk of seizure activity by decreasing smooth muscle contractility.

EQUIPMENT NEEDS:

A. Physician Order
B. Primary IV in place
C. IV Pump
D. Magnesium Sulfate in dosage as ordered by Physician – obtain premixed from Pyxis.
E. If not in pyxis obtain from Pharmacy.
F. IV Pump tubing
G. Reflex hammer
H. Fetal monitor (if undelivered)
I. Foley catheter, if ordered
J. Airway and resuscitation bag readily available
K. Vital signs machine (Blood pressure cuff if not available)
L. Oxygen and suction readily available
M. Calcium Gluconate 10% 4.65-9.3 mEq (10-20ml) immediately available

PRESCRIBED ACTION:

A. Before starting Magnesium Sulfate infusion, RN will:

1. Check for Sulfa allergies
2. Obtain baseline fetal strip if time permits
3. Explain Magnesium Sulfate therapy and common side effects to the patient (hot, flushed feeling, thirst, diaphoresis, diminished reflexes, flaccidity, weakness)
4. Gather equipment at bedside

Effective Date: ~~05/27/15~~

(12) Clinical Services
Inpatient Care Units:
Magnesium Sulfate in Pregnancy-HTN/Preeclampsia Care Guidelines
12-3086

APPROVED:

Medical Executive Comm.: ~~05/06/15~~

Board Of Directors: ~~05/26/15~~

5. Start primary IV with solution ordered by physician
6. Obtain baseline vital signs, including fetal heart tones (if applicable) and deep tendon reflexes
    - 0- No response
    - +1- Diminished
    - +2- Average
    - +3- Brisk
    - +4- Very brisk
7. Position patient wedged or turned on her right or left side at all times (Patient should never be flat on back)
8. Blood pressure should be taken when patient is on her side and the blood pressure cuff is on the upper arm

B. To prepare and infuse solution:

1. Use premixed solution from pharmacy of 40 Gms/1000 ml D5W

2. Bolus dose may range from 2-6 Grams given over 15-30 min. The usual dose is 4 Grams

3. Once bolus dose is infused, set pump to delivery maintenance dose ordered. Solution: 40 Grams Magnesium Sulfate/1000 ml IV (Premixed bag)

- 1 Gm= 25 ml/hr
- 2 Gm= 50 ml/hr
- 3 Gm= 75 ml/hr

(Set primary rate that, when added to Magnesium Sulfate infusion equals 125 ml/hr unless different IV rate ordered by physician. Total dosage should not exceed 40 Gms in 24 hours.)

4. Using pump tubing, piggy back infusion into primary IV port closest to the patient. **Magnesium Sulfate must always be infused with a pump, piggy backed into a primary IV.**

5. If patient is having a seizure, physician may order the bolus dose to be given over 5 minutes instead of 15-30 minutes.

C. During administration of the bolus dose and of the maintenance dose the RN will:

1. Observe and document as follows:

a. See attachment CMQCC Table 1.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Table 1. Nursing Assessment Frequency

A. Preeclampsia Without Severe Features (Mild)

	Preeclampsia without Severe Features (mild)		
	Antepartum*	Intrapartum*	Postpartum*
BP, Pulse, Respiration, SaO2	Every 4 hours	Every 60 min	Every 4 hours
Lung sounds	Every 4 hours	Every 4 hours	Every 4 hours
Deep consciousness Edema Assessment for headache, visual disturbances, epigastric pain	Every 8 hours	Every 8 hours	Every 8 hours
Fetal status and uterine activity	Every shift	Continuous	N/A
Temperature	Per facility protocol		
Intake and output	Every 1 hour with totals every 8 and 24 hours		

*This is the minimum frequency recommended for the patient NOT on magnesium sulfate.

B. Severe Preeclampsia Nursing Assessment Frequency

	Severe Preeclampsia Intrapartum and Postpartum for women on Magnesium Sulfate

BP, Pulse, Respiration, SaO2	• Every 5 mins during loading dose and q30 mins during maintenance of magnesium sulfate infusion
	• Can change to every 60 mins if any one or more of the following criteria are met:
	  ○ Preeclampsia without severe features (mild)
	  ○ BP stable without increases for a minimum of 2 hours
	  ○ No antihypertensives within last 6 hours
	  ○ Antepartum patient
	  ○ Latent phase of labor
	• Continuous SaO2 during magnesium infusion for intrapartum. For postpartum patient, check with vital signs

Lung sounds	Every 2 hours
Deep tendon reflexes & clonus, Level of consciousness Edema Assessment for headache, visual disturbances, epigastric pain	Every 4 hours
Temperature	Per facility protocol
Intake and output	Intake: • IV solutions and medication drips should all be on a pump • Total hourly intake should be ≤ 125 ml/hr • NPO with ice chips or as permitted by practitioner Output: • Insert foley with urometer Calculate hourly, end of shift, and 24-hour totals
Fetal status and uterine activity	Continuous fetal monitoring

C. Post Eclamptic Seizure and Magnesium Sulfate Toxicity

Post Eclamptic Seizure and Magnesium Sulfate Toxicity for Ante, Intra and Postpartum	
BP, Pulse, Respiration	Every 5 min until stable
O2 Sat & LOC	Every 15 min for a minimum of 1 hour
Fetal Assessment and Uterine Activity	Continuous

D. Acute BP Treatment with IV Medication

Acute BP Treatment with IV Medication: Ante, Intra and Postpartum	
BP, Pulse, Respiration	Every 5-15 min until stable
SAO2 and LOC	Every 5-15 min for a minimum of 1 hour
Fetal assessment and uterine activity	Continuous

EVIDENCE GRADING
Level of Evidence: III-C

REFERENCES

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TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Table 1: Classification of hypertension in pregnancy

Chronic hypertension	• BP of ≥ 140 mm Hg systolic or 90 mm Hg diastolic predating conception • Identified prior to 20 weeks gestation • Persists > 12 weeks postpartum • Use of antihypertensive medications before pregnancy
Superimposed preeclampsia or eclampsia on chronic hypertension	• New onset in a woman with hypertension prior to 20 weeks • Sudden increase in proteinuria if already present in early gestation • Sudden increase in BP • Development of HELLP syndrome • Development of headache, scotomata, or epigastric pain
Gestational hypertension	• 140 mm Hg systolic or ≥ 90 mm Hg without proteinuria occurring after 20 weeks gestation • Transient diagnosis with normalization of BP by 12 weeks postpartum • May represent pre-proteinuric phase of preeclampsia or recurrence of chronic hypertension abated in mid-pregnancy • May evolve to preeclampsia • Retrospective diagnosis
Preeclampsia	• Occurring after 20 weeks of pregnancy • BP ≥ 140 mm Hg systolic or ≥ 90 mm Hg diastolic or higher • Proteinuria 0.3 grams protein or higher in a 24-hour urine specimen OR ≥+1 per dipstick OR P/C ratio > 0.3 mg/dL
Eclampsia	• Presence of new onset grand mal seizures in a pregnant woman with preeclampsia (rule out idiopathic seizure disorder or other central nervous system pathology such as intracranial hemorrhage, bleeding arteriovenous malformation, ruptured aneurysm) • New onset seizures 48-72 hours postpartum (other central nervous system pathology is the likely reason for the seizure after 7 days)
Severe preeclampsia	If one or more of the following criteria are present: 1. Blood pressure of 160 mm Hg systolic or higher or 110 mm Hg diastolic or higher on two occasions at least 6 hours apart while the patient is on bed rest 2. Oliguria of less than 500 ml in 24 hours 3. Cerebral or visual disturbances 4. Pulmonary edema or cyanosis 5. Epigastric or right upper-quadrant pain 6. Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both 7. Thrombocytopenia 8. Renal insufficiency
HELLP Syndrome (subset of severe preeclampsia)	Hemolysis_Elevated Liver enzymes_Low Platelets

Adapted from ACOG Practice Bulletin #33, Reaffirmed 2013[1] and Hypertension in Pregnancy: Report of the American College of Obstetricians and Gynecologists' Task Force on Hypertension in Pregnancy, November 2013.[2]

Table 2: Hypertension in Pregnancy: Recommendations of the ACOG Task Force on Hypertension in Pregnancy: Executive Summary, published November 2013[2]

PRIOR Terminology (ACOG Bulletin #33, 2002, reaffirmed 2012)	Hypertension In Pregnancy: Report of the ACOG Task Force on Hypertension In Pregnancy, November 2013
Mild preeclampsia (BP > 140/90 mm Hg)	**(The Term 'mild preeclampsia' is discouraged for clinical classification)** **Diagnostic Criteria: Preeclampsia Without Severe Features*** **Blood pressure** • Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure • Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy and **Proteinuria** • Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection) or • Protein/creatinine ratio greater than or equal to 0.3* • Dipstick reading of 1+ (used only if other quantitative methods not available) Or in the absence of proteinuria, new-onset hypertension with the new onset of any of the following: **Thrombocytopenia** • Platelet count less than 100,000/microliter **Renal insufficiency** • Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease **Impaired liver function** • Elevated blood concentrations of liver transaminases to twice normal concentration **Pulmonary edema** **Cerebral or visual symptoms** *Each measured as mg/dL.
Chronic hypertension Gestational hypertension Superimposed preeclampsia	**No Change in Definition**
Severe preeclampsia: If one or more of the following criteria are present:	**Diagnostic Criteria: Severe Preeclampsia*** • Systolic blood pressure of 160 mm Hg or higher, or diastolic blood pressure of 110 mm Hg or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time) • Thrombocytopenia (platelet count less than 100,000/microliter) • Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both • Progressive renal insufficiency (serum creatinine concentration greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease) • Pulmonary edema • New-onset cerebral or visual disturbances

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PREECLAMPSIA EARLY RECOGNITION TOOL (PERT)

Preeclampsia Early Recognition Tool (PERT)

ASSESS	NORMAL (GREEN)	WORRISOME (YELLOW)	SEVERE (RED)
Awareness	Alert/oriented	•Agitated/confused •Drowsy •Difficulty speaking	•Unresponsive
Headache	None	•Mild headache •Nausea, vomiting	•Unrelieved headache
Vision	None	•Blurred or impaired	•Temporary blindness
Systolic BP (mm Hg)	100-139	140-159	≥160
Diastolic BP (mm Hg)	50-89	90-105	≥105
HR	61-110	111-129	≥130
Respiration	11-24	25-30	<10 or >30
SOB	Absent	Present	Present
O2 Sat (%)	≥95	91-94	≤90
Pain: Abdomen or Chest	None	•Nausea, vomiting •Chest pain •Abdominal pain	•Nausea, vomiting •Chest pain •Abdominal pain
Fetal Signs	•Category I •Reactive NST	•Category II •IUGR •Non-reactive NST	•Category III
Urine Output (ml/hr)	≥50	30-49	≤30 (in 2 hrs)
Proteinuria (Level of proteinuria is not an accurate predictor of pregnancy outcome)	Trace	•> +1** •≥300mg/24 hours	
Platelets	>100	50-100	<50
AST/ALT	<70	>70	>70
Creatinine	<0.8	0.9-1.1	>1.2
Magnesium Sulfate Toxicity	•DTR +1 •Respiration 16-20	•Depression of patellar reflexes	•Respiration <12

GREEN = NORMAL
Proceed with protocol

YELLOW = WORRISOME
Increase assessment frequency

# Triggers	TO DO
1	•Notify provider
≥2	•Notify charge RN •In-person evaluation •Order labs/tests •Anesthesia consult •Consider magnesium sulfate •Supplemental oxygen

**Physician should be made aware of worsening or new-onset proteinuria

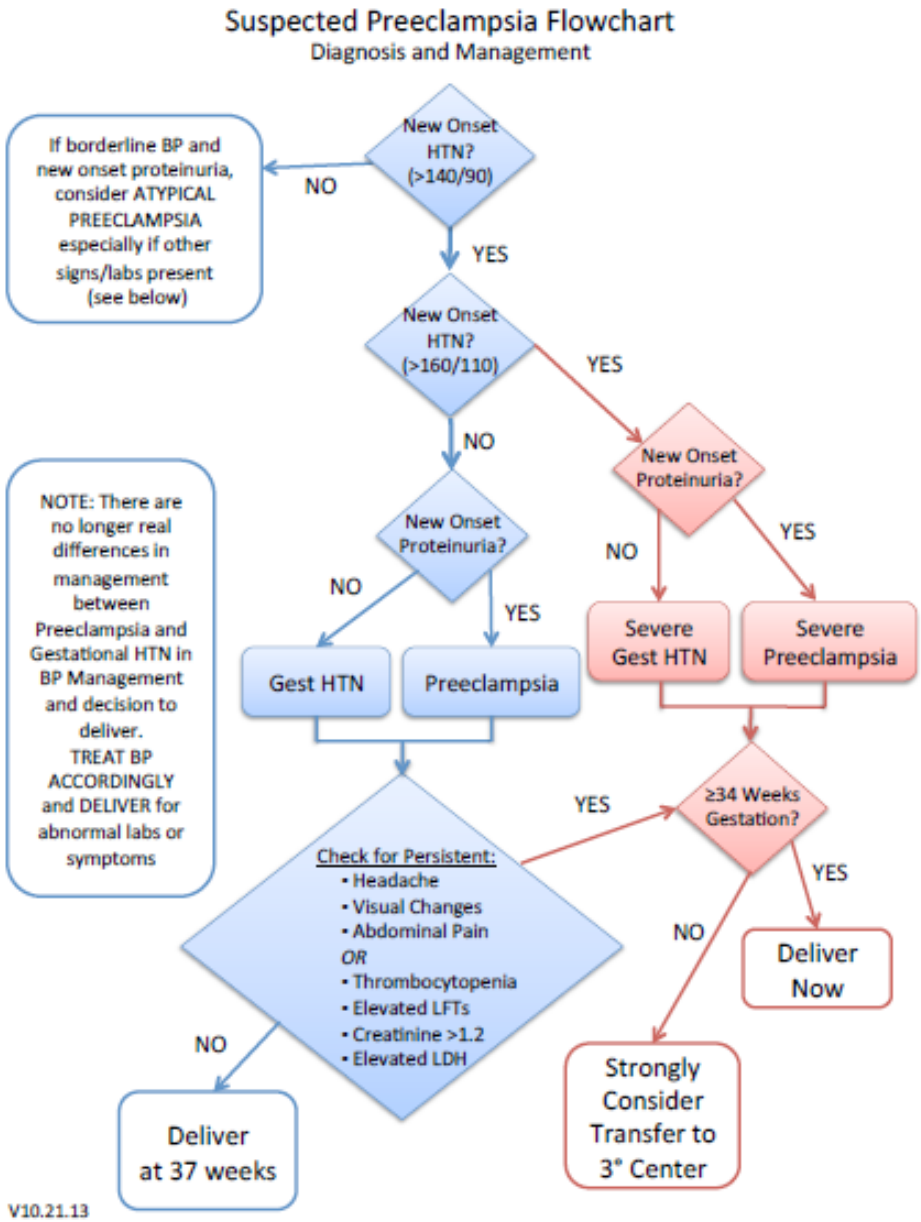
RED = SEVERE

Trigger: 1 of any type listed below	TO DO
1 of any type	• Immediate evaluation • Transfer to higher acuity level • 1:1 staff ratio
Awareness Headache Visual	• Consider Neurology consult • CT Scan • R/O SAH/Intracranial hemorrhage
BP	• Labetalol/hydralazine in 30 min • In-person evaluation • Magnesium sulfate loading or maintenance infusion
Chest Pain	• Consider CT angiogram
Respiration SOB O2 SAT	• O2 at 10 L per rebreather mask • R/O pulmonary edema • Chest x-ray

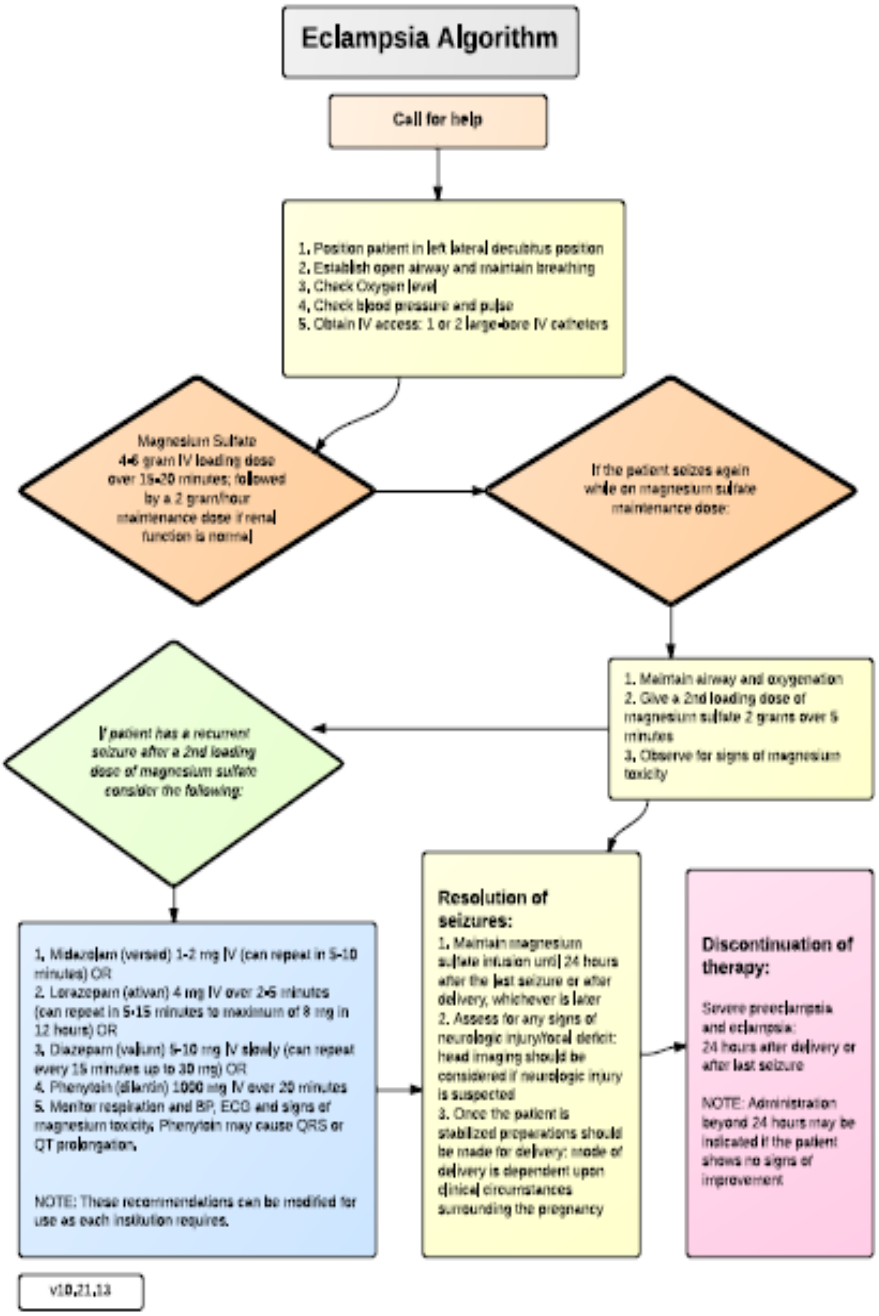
11.8.13.v1

Adapted from the Modified Obstetric Early Warning System (MEOWS) in "Saving Mothers Lives: Reviewing maternal deaths to make motherhood safer (2003-2005). The Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom 2007

Appendix C: Suspected Preeclampsia Algorithm Diagnosis and Management



ECLAMPSIA ALGORITHM



Descriptive Name:	Magnesium Sulfate in Pregnancy - HTN/ Preeclampsia Care Guidelines
Descriptive Type:	Revised
Document Number:	12-3086
Attachments:	7
Author:	Patti McCowan/Claudette Jones
Typist:	Melissa Arend
Creation Date:	11/01/12
Revision Date:	~~03/30/15~~4/24/18
Prev. Dist. Date:	01/24/13

Committee Review and Approval:	Approval Date:	Comments:
Pharmacy & Therapeutics Comm.	N/A~~04/06/15~~	Date change only
OB/GYN Service	N/A~~04/06/15~~	Date change only
MEC	N/A~~05/06/15~~	Date change only
Board of Directors	~~05/26/15~~	

Effective Date:	~~05/27/15~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service-Definitions

I. PURPOSE:

- To create better understanding of the job requirements, Central Service personnel shall know the meaning of commonly used words when sterilizing different articles:

Aerobic	Growing only in the presence of molecular oxygen. Staphylococci, pneumococci and tubercle bacilli are examples of aerobic bacteria.
Anaerobic	Growing only in the absence of molecular oxygen. Clostridium tetani (tetanus/lockjaw) and Cl. welchii (gas gangrene) are examples of anaerobic bacteria.
Antisepsis	The application of an antimicrobial chemical to the skin or mucous membranes to reduce the microbial population.
Antiseptic	An agent used for antisepsis. It may either kill microorganisms or inhibit their growth.
Asepsis	Freedom from infection; the absence of microorganisms that cause disease.
Aseptic Technique	Performance characterized by precautions for the constant exclusion of microorganisms. This means a method of working while maintaining a sterile area by avoiding contact with anything which is not sterile.
Autoclave	Common term applied to sterilizing by steam under pressure which kills all bacteria including spores.
Bactericide	A substance which destroys bacteria, but not spores.

Bacteriostatic	Inhibiting the growth or multiplication of bacteria.
Cleaning	The process used to free a surface from dirt or other extraneous organic or inorganic materials.
Concurrent Disinfection or Sterilization	Disinfecting or sterilizing process carried out during the course of a disease.
Contamination	The presence of a pathogenic agent on a body surface or inanimate article or in a substance.
Decontamination	(Decontam) - A process or method whereby an object or material is rendered free of microorganisms and safe for handling without gloves.
Degerm	Process of reducing the microbial flora of the skin or mucous membranes. The effect of antisepsis.
Detergent	Chemical substance or mixture of substances that has cleansing action because of a combination of properties, including lowering of surface tension, wetting action, emulsifying, dispersing action and foam formation.
Detergent - Germicide	A solution containing a detergent for cleansing purposes and a germicide for antimicrobial action.
Disinfectant	A chemical agent which rapidly destroys most microorganisms. A disinfectant is usually stronger than an antiseptic. Since a concentration of chemicals that injures bacterial cells may injure human tissue cells as well, most disinfectants should not be used on skin or mucous membranes.
Disinfection	Any process, chemical or physical, which removes, controls, or destroys the growth of microorganisms. While chemical disinfection rapidly kills bacterial cells, it may not kill all spores and viruses.
Infection	Multiplication of pathogenic microorganisms, in or on body tissue.
Infectious Agent	A pathogenic microorganism.
Microorganisms	A minute living organism, invisible to the naked eye.

Nonpathogenic Microorganisms	Microorganisms which do not produce disease.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Definitions

Descriptive Type: New Policy

Document Number: 12-3090

Attachments: None

Author: ~~Paul Stratman~~ David MacDonald~~-~~

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- Storage of Clean Supplies and Equipment

I. POLICY:

- Clean supplies are to be placed in proper storage areas. Shelves, cupboards and drawers are cleaned once a month with hospital-approved detergent-germicide, following cleaning protocols for carts and storage areas. Cleaning is required as needed of all carts used to transport clean supplies.

- There is an area provided for storage of patient care items and admission kits, orthopedic supplies and some small equipment. Additional carts for clean supplies can also be found in clean work and storage area.

- Clean equipment found directly behind mobile storage racks mentioned above includes thermal blankets, alternating air mattress, k-pads, SCD machines and sleeves.

- All supplies stored in the clean storage area shall be stored clean. Items intended for one time use are never reused. Patient take home items are not acceptable for cleaning and storage after patient's usage. They shall be discarded.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Storage of Clean Supplies and Equipment
12-3091

Descriptive Name: Central Service-Storage of Clean Supplies and Equipment

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3091

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- Stock Rotation

I. PURPOSE:

II. POLICY:

All sterile supply stock shall be rotated; oldest supplies shall be used first.

III. WHO MAY PERFORM:

Central Service Technician

IV. PROCEDURE:

- In a single line, place newest supplies in rear, pull supplies for use from front.
- In a pile of supplies, place newest on bottom, pull from the top of the pile.
- On a shelf, place newest supplies on left, pull from right.
- Supplies, therefore, proceed from left to right, bottom to top, back to front.

KEY POINT:

Items whose packaging has been damaged or which have exceeded their expiration date shall be forwarded to the Central Service Manager who will determine the final disposition of the item.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Stock Rotation
12-3092

Descriptive Name: Central Service-Stock Rotation

Descriptive Type: New Policy

Document Number: 12-3092

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service-Dress Code

I. POLICY:

- The following dress code applies to all personnel working in the Central Service area and shall be strictly enforced.
  - Lockers shall be provided for all personnel working in the Central Service area.
  - A clean scrub uniform shall be worn while on duty.
  - Caps shall be worn at all times by personnel in the restricted area.
  - All visitors and engineers shall be supplied with a cover gown or a jump suit and head coverings when entering the restricted area.
- Decontamination Area Attire:
  - Clean scrub attire:
    - To be changed daily and as needed
  - Head covering
  - Shoe covers:
    - Remove shoe covers when leaving the decontamination area
  - Cover gown:
    - Non-permeable

- Prevents clothing from becoming wet

- Rubber gloves:
  - Shall be worn at all times when handling contaminated items
- Goggles or mask with eye shield:
  - To be worn during instrument decontamination
  - A face shield is preferable in decontamination

- Processing Area Attire:
  - Clean scrub attire:
    - To be changed daily and as needed
  - Head covering

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Dress Code

Descriptive Type: New Policy

Document Number: 12-3093

Attachments: None

Author: ~~Paul Stratman~~ David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 09/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service-Quality/Environmental Control

I. POLICY:

- The following policies define the contamination control responsibilities for the Central Service personnel at Tulare Regional Medical Center.
    - Damp dust and wash all shelves on which sterile supplies are stored, on a monthly basis.
        - Use hospital-approved cleaning solution or germicidal cleaner.
    - Wipe all sterile storage areas with germicidal cleaner on a bimonthly basis.
    - Stock supplies and syringes to all appropriate locations, acute units and other areas on a daily basis.
    - Restock Central Service stock carts one time per shift (days and nights).
    - Attach proper identification labels to all stock.
    - Rotate all stock each time supplies are restocked in any area. The oldest dated items are placed in the front.
    - Sterile supplies are to be stored in an area separate from non-sterile supplies. They are not to be mixed.
    - All items sterilized are to be dated, identified, expiration dated (if event-related shelf life not used in the facility) and initialed by the individual processing them.

- When sterile supplies are dropped to the floor or become dampened by moist contact or solution, they are contaminated and shall be re-sterilized or discarded.

- When surgery packs and other sterile items are taken from autoclaves, be sure they are placed on Central Service dry racks chosen for sterile supplies only. Do not mix sterile items with un-sterile items on drying racks.

- All sterile supplies processed in Central Service are checked and re-sterilized as needed. This includes items in drawers, shelves and carts.

- Examine all wraps and disposable trays or packages carefully. Any package breaks, excessive air, solution leakage or other defects noted indicates article is un-sterile and unusable - discard immediately. Report incident to charge technician or manager.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Quality/Environmental Control

Descriptive Type: ~~New~~ Revised Policy

Document Number: 12-3094

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 09/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- Maintenance and Service Contract Agreement Manufacturer's Responsibility

I. POLICY:

- A permanent maintenance agreement (PMA) contract has been established with Reynovo Bio Med Services. They are responsible for sterilizers, aerators, electrosonic cleaners and other equipment in the Surgical Services Department and Central Service.
- Maintenance agreements include:
  - Routine servicing (quarterly)
  - Replacement of defective parts
  - Repair of broken parts
  - Any other technical defects of servicing
- Documented and dated copies of servicing shall be sent to the Engineering Department and/or Central Service Manager.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Maintenance and Service Contract Agreement Manufacturer's Responsibility
12-3095

Descriptive Name: Central Service-Maintenance and Service Contract Agreement Manufacturer's Responsibility

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3095

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- Hours of Service

I. POLICY:

- The hours of service are as follows:
  - Day Shift
    - 6:00AM 2:30 PM (1 person)
    - 7:00AM 3:30PM (1 person)
  - Evening Shift
    - 3:00PM 11:30PM (1 person)
    - Per diem as needed (OR Processing 3 Persons
- Any employee may be scheduled to work any or all of the above mentioned shifts. In an emergency, the standard tour of duty may be altered as required. Also any employee may be asked to vary hours according to the needs of the hospital.
  - Central Service is provided 18 hours, 5 days a week from 6:00am to 11:30pm; on call weekends and holidays.
  - Nursing equipment services are also provided after hours by the Nursing Supervisor on duty.
  - Sundays and holidays are not normal sterilizing days, therefore on Sundays and holidays, Central Service personnel are on call.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Hours of Service
12-3096

Descriptive Name: Central Service- Hours of Service

Descriptive Type: ~~New~~ Revsied Policy

Document Number: 12-3096

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Central Service- Physical Layout

I. PURPOSE:

To describe the physical layout of Central Service.

II. POLICY:

- Central Service shall be divided into two (2) areas, designated as "clean" and "dirty", which are clearly marked.
    - The "clean" area will be used for processing and sterilization of clean items, to include the preparation and packaging and storage of instrument and treatment trays and sets. The sterilizers are located in this area.
    - The "dirty" area will be used for decontamination of all soiled items, including the washing and drying of contaminated items.
- These two areas will be physically divided, and the integrity of each area will be maintained. Only clean items will be taken into the processing area, and traffic will be strictly controlled. Only properly attired personnel will enter the clean processing area and decontamination area.

I. RESPONSIBILITY:

Central Service personnel are responsible for maintaining each area as designated.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Physical Layout
12-3097

Descriptive Name: Central Service-Physical Layout

Descriptive Type: Revised Policy

Document Number: 12-3097

Attachments: None

Author: Paul Stratman

Typist: Maritza Sevillano

Creation Date: 9/16/15

Revision Date: 3/7/18

Prev. Dist. Date: 2/25/16

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~11/18/15~~N/A	Date change only
MEC	~~01/27/16~~N/A	Date change only
Board of Directors	~~02/24/16~~	

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- After Hours Acquisition of Supplies and Equipment

I. POLICY:

- Only the House Supervisor or designee is permitted in Central Service for emergency or "after hours" requisition.
    - The keys are on the Nursing Supervisor's master key ring.
    - A supply locator shall be maintained in Central Service to facilitate the acquisition of items after hours.
    - The Nursing Supervisor will bring a charge card or slip for the appropriate patient, in order to charge for all supplies or equipment at the time of issue.
    - In order to reduce the need for emergency or "after hours" acquisitions, the par levels of supplies shall be closely monitored by the Central Service Manager, to provide basic supplies in sufficient quantity.
    - The Central Service Manager will maintain close contact with the patient care unit staff and Nursing Administration to ensure that problems and concerns are promptly communicated and corrected as speedily as possible. Nursing Administration will also be informed if a pattern or after hours acquisition abuse develops.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-After Hours Acquisition of Supplies and Equipment
12-3098

Descriptive Name: Central Service-After Hours Acquisition of Supplies and Equipment

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3098

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: ~~9/16/15~~3/7/18

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Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
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Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service- Traffic Control

I. PURPOSE:

II. POLICY:

- Traffic control is strictly enforced in Central Service Department:
  - All doors opening into the main corridor are to remain closed at all times.
  - Decontamination door is the only door used to enter Central Service.
    - Personnel who are not members of Central Service but find it necessary to enter the department (engineers, servicemen, physicians and administrative personnel, etc.) must don shoe covers, head and cover-up clothing before being allowed to enter the department.
  - The flow of traffic in and out of the department will be kept to a minimum.

Effective Date: ~~09/29/16~~

APPROVED:

Medical Executive Comm.: ~~09/14/16~~

Board Of Directors: ~~09/28/16~~

(12) Clinical Services
Inpatient Care Units:
Central Service-Traffic Control
#12-3099

Descriptive Name: Central Service-Traffic Control

Descriptive Type: ~~New~~Revised ~~-~~Policy

Document Number: 12-3099

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

Revision Date: ~~N/A~~3/7/18

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Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	~~03/21/16~~	
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MEC	~~09/14/16~~	
Board of Directors	~~09/28/16~~	

Effective Date: ~~09/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service-Environmental Cleaning of Central Service

I. PURPOSE:

To maintain a standard of environmental cleanliness.

II. POLICY:

III. PROCEDURE:

- All shelves shall be wiped with an approved antibacterial solution weekly.
- Wire racks and carts shall be cleaned on a weekly basis with a hospital approved germicide.
- Table tops, counters, sinks and cupboard doors require daily cleaning.
- Environmental Services shall clean all walls weekly, and floors on a daily basis.
- Air conditioning vent surfaces are to be cleaned on a weekly basis by Environmental Services.
- Air conditioning filters will be changed by the Engineering Department on a routine basis.
- All cleaning procedures shall be documented on the appropriate cleaning checklist by the person performing the cleaning. The checklist shall be dated and initialed.

IV. RESPONSIBILITY:

- Central Service personnel are responsible for completion and documentation of assigned environmental cleaning.
- Environmental Services and Engineering Departments are responsible for completion and documentation of their designated environmental cleaning.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Environmental Cleaning of Central Service

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3100

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

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Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	~~03/21/16~~	
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MEC	~~09/14/16~~	
Board of Directors	~~09/28/16~~	

Effective Date: ~~09/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Central Service-Infection Control

I. PURPOSE:
To provide infection control guidelines for Central Service; including standardized policies and procedures for receiving, processing, storing and issuing various kinds of materials which are purchased pre-sterilized, sterilized in the hospital and certain equipment requiring cleaning and processing in an area designated, equipped and staffed for this purpose.

II. POLICY:

III. RESPONSIBILITIES:

- Central Service Manager:
  - Formulates, in writing, Infection Control policies and procedures for Central Service.
  - Provides written procedures for the following:
    - Handling of disposable and non-disposable items
    - Checking and returning of outdated items to Central Service
    - Storage and rotation of sterile supplies
    - Dating of sterile processed supplies
    - Separation of clean supplies from those to be processed
    - Handling of contaminated supplies; decontamination
    - Proper methods for sterilization

- Cleaning and disinfection of equipment which cannot be sterilized

- Establishes proper flow patterns for handling supplies and traffic and maintains separate dirty/clean work areas.
- Maintains all requirements of cleaning, wrapping, packaging and storing of sterile items processed or stored within the hospital.
- Provides and documents continuing education in infection control and safety for Central Service personnel.
- Maintains personnel health standards and required dress attire policies.
- Reports potential infection hazards to the Infection Control Practitioner.
- Is a member (or assigns a representative of the department) of the Infection Control Committee.

- Central Service Technician:
  - Shall be qualified by training and experience, and operates under the supervision of the Central Service Manager.
  - Shall observe all policies and procedures of the Central Service Department.

- Infection Control Practitioner:
  - Reviews all infection control practices and processes in Central Service.
  - Orders environmental cultures as indicated.
  - Assists in the preparation and presentation of educational infection control programs.
  - Acts as a resource person.
  - Makes periodic prevalence rounds to determine adherence to guidelines.

- Infection Control Committee:
    - Reviews and approves all policies and practices relevant to infection control.
    - Serves as consultant to all of the above.

INFECTION CONTROL PRACTICES:

- Employee Health:
    - Employees shall comply with the Employee Health Program.
    - Personnel shall not work if they have skin, respiratory or gastrointestinal infections.
    - Eating, drinking or smoking shall not be permitted in Central Service.
    - Personnel off duty for three (3) or more days because of an illness shall be cleared by a physician before returning to work.
    - Personnel with a communicable disease shall be referred to the Infection Control Practitioner for follow-up.
- Personal Hygiene:
    - Cleanliness and good personal hygiene habits are mandatory.
    - Frequent and thorough hand-washing is mandatory.
    - Gloves shall be used when handling and sorting soiled bio-hazardous articles.
- Dress Code:
    - Keep nails short; use nail sticks to clean under the nails.
    - Remove excessive or hanging jewelry and other ornaments before reporting to duty. These items often have bacteria which can be transmitted to clean or sterile materials.

- Hair shall be completely covered with disposable head cover while assembling trays and discarded at end of shift. Shoe covers will be worn as required.

- Personnel shall wear designated scrub uniforms - one day use only. Scrubs will be changed if exposed to spills.

- Personnel shall wear impermeable cover gowns, gloves, goggles/face shields and shoe covers when cleaning soiled bio-hazardous instruments, utensils, etc., and change appropriately when leaving dirty areas.

- Visitor Control:

  - With the approval of the Central Service Manager or designee, visitors may be allowed to enter the Central Service area with the proper apparel:

    - Head cover

    - Cover gown/jump suit

    - Shoe covers

- Education:

  - Programs in infection control measures begin in orientation and continue with on-the-job training and in-service education. Personnel will attend annual update yearly.

  - Basic training in aseptic techniques, personal hygiene, sterility, storage and safe handling practices shall be a requirement at the time of hire.

  - Continuing education specific to Central Service is strongly encouraged.

- Indications for Sterilization/Disinfection:

  - Patient care equipment that enters normally sterile tissue or the vascular system, or through which blood flows, shall be sterile.

  - Laparoscopes and other scopes that enter the peritoneal cavity shall be subjected to a sterilization procedure before each use.

- Endoscopes and respiratory therapy equipment that go though mucous membranes shall be subjected to a sterilizing procedure before each use.

- Method of Processing:
  - Patient care equipment contaminated with blood shall be sterilized; if this is not feasible, it shall receive high-level disinfection.
  - Most environmental surfaces contaminated with blood shall be cleaned with a solution of hospital-approved germicide.
  - Other patient care and environmental objects that are potentially contaminated with virulent microorganisms shall be processed accordingly with the hospital-approved germicide solution.

- Equipment and Packaging:
  - The most reliable type of sterilization available for each type material will be used.
  - Non-sterile items:
    - Areas in Central Service are designated for receiving, servicing, cleaning, storing and issuing of non-sterile equipment.
  - Sterile reusable equipment and material:
    - Must be processed in two (2) physically separate areas by separate staffs. If this is not possible, careful hand-washing and uniform change shall be required before the move from "dirty" to "clean" areas.
    - Written procedures are established for washing, wrapping and arranging packages, and the various types and sizes of materials or containers used.
    - Equipment and supplies shall be purchased on the basis of their reaction to steam or plasma i.e. Sterrad. Use chemicals only when absolutely necessary.
  - Sterile supplies:
    - Proper storage and handling of sterile supplies shall be maintained to prevent contamination.

- Stock shall be rotated to reduce the need for re-sterilization.
- Procedures are written and maintained in the department for establishing shelf life of sterile items and/or for checking outdated supplies or package integrity in event-related shelf-life sterility.
- Any sterile reusable materials that leave Central Service and are then returned are considered contaminated and shall be cleaned, re-sterilized and/or reprocessed.

- Disposable items:
  - Written procedure for staff handling disposable items shall include inspection of packaging, expiration date or package integrity, stock rotation, inventory control and disposal.

- Traffic and Supply Control:
  - Good flow patterns shall be established for handling supplies and traffic.
  - Transportation system shall be used as "one-way" systems for either clean or dirty supplies.

- Environmental Services:
  - All work surfaces, shelves and fixtures shall be cleaned daily with approved germicidal cleaner.

- Engineering:
  - Preventive maintenance records are kept on equipment in the Bio Med/Engineering Department. Please refer to equipment lists.
  - Equipment shall be carefully tested and inspected before it is cleaned and dispensed for patient use by Central Service personnel. Rental equipment must be inspected and approved by the Engineering Department prior to use on any patient.
  - Manufacturers' recommendations shall be followed regarding care, use and/or repair of equipment.

- Decontamination/Cleaning:
    - Objects to be disinfected or sterilized shall be thoroughly cleaned to remove all blood, tissue, food and other debris, before reprocessing. The using department shall return objects to Central Service in plastic bags to confine and contain contamination.

CONTROLS OF THE SYSTEM:

- Administrative:
    - Autoclave indicating tape:
        - Indicating type autoclave tape, indicating labels or indicating printed legends shall by affixed to or printed on all hospital assembled packages intended for sterilization. Tape, label or legend shall be examined after sterilization and also before use to make sure that it indicates adequate exposure to the appropriate sterilizing process.
    - Sterilizer logs, chart chemical/biological tests and spore tests shall be maintained as required.
    - Expiration dates:
        - See event-related shelf-life sterilization.
    - Lot control:
        - Lot control numbers shall be placed on each package for later retrieval if needed.
- Process Control:
    - Recording charts and gauges:
        - Shall be examined by the sterilizer operator at the beginning and end of each cycle (temperature and pressure). There is a written procedure for this activity. Records shall be maintained per hospital/regulatory requirements.
    - Chemical indicators:

- A temperature accurate chemical indicator is used at the center of each package of hospital-assembled material and among materials which are heat-sterilized without packaging.

- Biological Indicators:
  - There is a written biological indicator procedure for steam or plasma.
- Rotation of Supplies:
  - There is a written procedure covering the rotation of supplies, including shelf life of various packaging and event-related shelf life.
- Autoclaves and Sterilizers:
  - Autoclaves and sterilizers will be maintained in operating condition at all times.
  - Instructions for operating autoclaves and sterilizers are posted in the area where the autoclaves and sterilizers are located.
  - Written procedures are developed, maintained and available to personnel responsible for sterilization of supplies and equipment that include, but are not limited to, the following:
    - Time, temperature and pressure for sterilizing the various bundles, packs, dressings, instruments, solutions, etc.
    - Cleaning, packaging, storing and issuing of supplies and equipment
    - Dating of materials sterilized
    - Loading of the sterilizer
    - Daily checking of log sheets recording and indicating thermometers and filing for seven (7) years of recording thermometer charts

- Weekly (on steam; biweekly on gas) bacteriological test, the bacterial organism used and filing for seven (7) years of the test results
- Length of aeration time for materials gas-sterilized is eight (8) to 30 hours. See manufacturer's recommendations.

- Recall:
  - There is a written system for recall of all sterilized goods.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Infection Control

Descriptive Type: ~~New~~ Revised Policy

Document Number: 12-3101

Attachments: None

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 9/16/15

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Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	~~04/18/16~~	
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MEC	~~09/14/16~~	
Board of Directors	~~09/28/16~~	

Effective Date: ~~09/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Central Service Department Cleaning

I. POLICY:

- Central Service is a housing area for sterile and clean supplies intended for patient usage. Bacteria shall be controlled as much as mechanically and humanly possible by all employees who work in this area.

- Establishing a clean work and storage environment is a constant aim that shall be achieved in Central Service in order to maintain an asepsis state. Cleaning procedures shall be considered one of the most important tasks. and each technician or other staff member is responsible for cleaning the area he/she has been assigned to. In addition, those areas that are not used exclusively to store or handle direct patient contact items, but are a part of the department, are to be kept clean and in order. This is the responsibility of all Central Service personnel.

- The Environmental Service Department is responsible for cleaning the floors, walls, overhead vent surfaces and hoppers

- Central Service is responsible for all other cleaning tasks.

    - For all cleaning assignments, obtain clean cloths, clean basins, water, hospital-approved soluble detergent and a germicide solution. Be sure to follow mixing instructions for all cleaning solutions and germicide solutions. This applies to all of the following work assignments:

        - Surface Area Cleaning:
            - Surface cleaning, shelves, closets, woodwork, tables, etc. Purpose: To provide for cleanliness and orderliness on a continuing basis for supplies and equipment.

- Closed and Open Shelving - Sterile Area:

Once a week or more often as needed, wash shelves with disinfectant solution starting from the top down. allow to air dry

- Work Tables and Counters:
  - . The continuous cleaning of these surface areas isare necessary throughout the day. A dampened cloth (germicide solution) is used for continued cleaning.
- Work Areas:
  - All work areas must be kept neat and clean at all times. Allow 10 minutes before going off duty to make certain the work area is in proper order.
- :
  - .
- Closed Sterile Supply Carts:
    - closed carts used for sterile instruments and supplies movement.
    - All carts used for transport of sterile instruments and supplies shall upon their return to CPD be wiped down with a germicidal solution and allowed to air dry according to the Mfr's. IFU.
- Cart Wheels:
  - Shall be checked daily to remove any debris or lint which may adhere to wheels. Use soap and water solution for cleaning. Rinse well.
- Central Service's Storage Room:
  - . Storage racks and shelves must be cleaned and stock neatly arranged. . Supplies must be 18 inches from the ceiling as sprinkler system (fire) must be kept clear. Do not store case goods on the floor.

- Satellite Areas:
  - Cleaning procedures are identical to departmental cleaning and sterile storage areas, as this area is your clean and sterile supply distribution point.
  - All storage areas used for the purpose of sterile supplies must be kept neat and clean at all times. All areas are on a rotating schedule for terminal cleaning. Should be done Bimonthly. Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service Department Cleaning

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3102

Attachments: No

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

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Surgery Committee	~~08/17/16~~	
MEC	~~09/14/16~~	
Board of Directors	~~09/28/16~~	

Effective Date: ~~09/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Central Service-Storage of Sterile Supplies

I. PURPOSE:

To outline proper storage of sterile supplies.

II. POLICY:

- All sterile supplies shall be stored in a secure location which maintains the integrity of the sterile item.
  - All storage areas shall be clean, dry, protected from moisture, vermin or insect excreta.
  - Before storage, all sterile items shall be checked for the following:
    - Make certain items are completely dry
    - Integrity of the outer wrap
    - Coloring of sterile indicator tape, date prepared, initialed
    - Sterilization
    - Sterile expiration date (if item is not included in event-related sterility program)
    - Lot number labels

- All sterile cloth and paper wrap items are stored in the Central Service sterile area in closed shelf section or in drawers as designated. These items shall be double-wrapped.

- Stock shall be rotated so that items do not outdate. Stock is checked monthly in order to verify that no item in the sterile storage area is outdated. Stock shall be rotated so that older stock is in front and newer stock is placed in back or older stock is on the right and newer stock is on the left. Paper wrappers also may become brittle with age and this compromises sterility.

- The closures of sterile items shall be tamper proof and impossible to reseal. If there is a suspicion of incomplete closure, the item shall not be used.

- Cases and cartons shall not be placed directly on the floor when stored. They shall be stocked on lower shelves or platforms.

- A cloth or paper-wrapped tray or items which are seldom used shall be protected by protective plastic wrap immediately after a thorough cooling period. Heat seal or tape opening.

- All storage areas shall be clearly labeled. Any item sterilized by the hospital shall be identified on outside of the wrap with the following information:

    - Name of item

    - Month, day and year

    - Sterile expiration date (if item is not included in event-related sterility program)

    - Lot and load number label or stamp

    - Initials of the Central Service employee who processed and wrapped the item

- Sterile supplies shall be separated from clean supplies:

    - A clean non-sterile storage area is designated for this purpose.

    - Ideally, items shall not be stacked or piled on top of each other in storage. If space determines this must occur, then items shall be of the same size and shape, neatly stacked, with item identification plainly visible.

- Do not store any item in the sterile or clean area in the original carton. Articles are to be removed from the shipping boxes and placed on small transfer cart which can be wheeled into the area.
- All sterile supplies are to be stored at least eight (8) to 10 inches above floor level to allow for cleaning and wet mopping and to lessen the possibility of contamination. To allow for air circulation, supplies are to be stored 18 inches from the ceiling, and to reduce the possibility of bacteria invasion and for air circulation purposes, a minimum distance of two to three (2-3) inches from the wall is maintained.

- Storage of sterile supplies shall be done under conditions which tend to preserve, not threaten the integrity of the packaging.

  - Traffic in storage areas shall be kept to minimum.

  - Rubber bands, paper clips, etc., shall not be placed around "paper or plastic" packages.

  - Supplies shall be handled as little as possible, to reduce risk of damage.

  - When stored in drawers, packages shall not be "packed in", due to risk of tearing or sliding when drawer is opened.

  - No sterile packages of any type shall be placed next to or below any sink. Water contaminates sterile packages automatically and necessitates their reprocessing (or disposal) before use.

I. RESPONSIBILITY:

All personnel in Central Service, Materials Management and other areas with sterile supplies are responsible for proper storage of these supplies.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service Storage of Sterile Supplies

Descriptive Type: ~~New~~ Revised Policy

Document Number: 12-3103

Attachments: No

Author: ~~Paul Stratman~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 09/16/15

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
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Surgery Committee	~~08/17/16~~	
MEC	~~09/14/16~~	
Board of Directors	~~09/28/16~~	

Effective Date: ~~09/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Central Service—Standard Precaution

I. PURPOSE:

II. POLICY:

- Standard Precautions combine the features of universal precautions and body substance isolation. Standard Precautions apply to all patients regardless of their diagnosis or suspected infection status. Standard Precautions apply to the following:
  - Blood
  - All body fluids, secretions and excretions except sweat whether or not they contain visible blood
  - Non-intact skin
  - Mucous membranes
- Standard Precautions include the following:
  - Hand Hygiene - Adherence to hand hygiene techniques including washing hands with soap and water or use of an alcohol-based hand rub, reduces transmission of antimicrobial resistant organisms and overall infection rates. If hands are visibly dirty or contaminated with protein material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. If hands are *not* visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations.
    - See hand hygiene policy for procedure.

- Gloves - Gloves are to be worn when touching blood, body fluids, secretions, excretions and other contaminated items. Clean, non-sterile gloves will be adequate. Gloves shall be changed between tasks and procedures after contact with material that may contain a high concentration of microorganisms.

- Mask, Eye Protection, Face Shields - When performing procedures that may be likely to generate splashes or sprays of blood, body fluids, secretions or excretions, wear a mask and eye protection or a face shield. This will protect the mucous membranes of the eyes, nose and mouth.

- Gowns - When performing procedures that may be likely to generate splashes or sprays of blood, body fluids, secretions or excretions, wear a gown to protect the skin and to prevent soiling of clothing. Always remove the soiled gown as soon as possible and wash hands.

- Patient Care Equipment - All patient care equipment that is soiled with blood, body fluids, secretions or excretions shall be handled in a manner that will prevent skin and mucous membrane exposures. Single use, disposable items must be disposed of properly. Make sure that reusable equipment has been cleaned and reprocessed appropriately, prior to use on another patient.

- Linen - Used linen soiled with blood, body fluids, secretions and excretions will be handled, transported and processed in a way that prevents skin and mucous membrane exposure, contamination of clothing and the transfer of microorganisms to the environment.

- Occupational Health and Blood borne Pathogens - Avoid injuries if at all possible when using needles, scalpels and other sharp instruments. Place all contaminated needles, syringes, scalpel blades and other sharp items in designated puncture-resistant containers. These containers should be located as close as possible to the area where the items are used.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Central Service-Standard Precaution

Descriptive Type: ~~NEW~~ Revised Policy~~POLICY~~

Document Number: 12-3104

Attachments: None

Author: ~~Paul Stratman/~~David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 11/15/15

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Infection Prevention	~~03/21/16~~	
MEC	~~04/13/16~~	
Board of Directors	~~04/27/16~~	

Effective Date: ~~04/28/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Hospital Provided Scrubs in the Operating Room

PURPOSE:
To maintain the optimal infection free environment in the Operating Room, all staff shall wear proper surgical attire, provided by the hospital.

POLICY:
Hospital - provided and laundered scrubs will be provided to Operating Room, Endoscopy, Anesthesia, Central Processing, Cardiac Cath and Vascular Lab personnel. Personnel authorized to wear these scrubs change upon arrival and departure.

The use of hospital provided and laundered scrub uniforms are based on the following rationale supported by the Center for Disease Control to:

- Reduce the bioburden in "clean" or "restricted" areas of the hospital.
- Provide changes of hospital laundered clothing to those employees at greatest risk of blood and body fluid contamination in their daily work, while preventing the transport of contaminated items into the community.

PROCEDURE:

Hospital laundered scrubs will be provided for the following areas:

- Anesthesia
- Birthing Suite
- Cardiac Cath and Vascular Lab
- Electrophysiology- scrubs should be worn only during procedures
- Central Processing and Distribution
- Labor and Delivery
- Operating Room
- Endoscopy

Effective Date: ~~03/29/16~~

APPROVED:

Medical Executive Comm.: ~~03/10/16~~

Board Of Directors: ~~03/29/16~~

(12) Clinical Services
Inpatient Care Units:
Hospital Provided Scrubs in the Operating Room
12-3106

- Radiology-Interventional procedure and OR personnel only
- Surgical and Obstetrical Physicians

Personnel authorized to wear hospital-laundered scrubs will wear the green and teal colors. Service specific scrubs may be worn but will not be laundered by the hospital. Services will be represented by color. Color is to be determined by the service team.

Scrub uniforms, whether hospital-provided or service-specific, will consist of a matching top and bottom.

Additional attire in any Operating Room, Labor and Delivery and any invasive Procedure Units must adhere to the following guidelines:

- Warm-up jackets may be worn provided they are clean and lint-free;
- Due to their high lint content, fleece jackets, sweatshirts and sweaters may **NOT** be worn in any Operating Room, Labor and Delivery or Invasive Procedure Suites. High lint materials harbor bacteria. As personnel move around, the friction frees bacteria with subsequent shedding into the environment;
- Fleece jackets may be worn over scrubs when traveling to and from any OR, Labor and Delivery or any Invasive Procedure Suites; and,
- Cotton-blend, lint-free shirts may be worn under scrub attire.

Scrubs do not provide protection from blood or body fluids. Personal protective equipment (e.g., gortex gown) must be worn over scrubs when splashes to skin or clothing are anticipated.

Hospital-provided scrubs, which are visibly soiled or wet, must be changed. If the scrub attire becomes contaminated with blood or body fluids, a clean pair of scrubs will be provided to the employee. If the garment is soiled, it should be removed in such a way so as to avoid exposure to the skin. The employee is to contact his/her supervisor to obtain additional scrubs. Each employee is allowed to have his/her weekly allotment of scrubs.

REFERENCES:

Belkin, N.L. Use of scrubs and Related apparel in Health Care Facilities, Association for Professional in Infection Control and Epidemiology, Inc.; American Journal Infection Control 1997; 25:401-4.

Selking, N.L. Home Laundering of Soiled Surgical Scrubs: Surgical Site Infections and the Home Environment, Association for Professionals in Infection control and Epidemiology, Inc.; Practice Forum, 2/01, 29:1.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Hospital Provided Scrubs in the Operating Room

Descriptive Type: ~~New~~Revised Policy

Document Number: 12-3106

Attachments: None

Author: David MacDonald

Typist: Maritza Sevillano~~/Melissa Arend~~

Creation Date: 02/22/16

Revision Date: ~~N/A~~3/7/18

Prev. Dist. Date: N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~02/24/16~~	
MEC	~~03/10/16~~	
Board of Directors	~~03/29/16~~	

Effective Date: ~~03/29/16~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Discharge of Patient from OR to the Post Anesthesia Recovery Unit (PACU)

PURPOSE
Registered Nurse responsibilities during patient discharge from the OR and transport to the PACU.

POLICY
An Operating Room Registered Nurse will physically accompany the patient and

Anesthesiologist to the PACU. Patients will receive continuous care from the Operating Room to the PACU by a Registered Nurse. The steps of this procedure will be followed when caring for patients during transport from the OR to the PACU.

PROCEDU RES

A. When the surgical procedure is completed the RN will continue to assess the patient's status, assist with any dressings, and ready the patient for transport.

B. When deemed appropriate by the anesthesiologist and the patient is physiologically stable the patient will be transported by lift or gurney to the PACU.
   - The patient will be transported with 02. Patients will also be monitored during transport as needed/per anesthesia request.
   - Both the anesthesiologist and the RN will accompany the patient to the PACU except in the case of a local anesthetic only.

C. Upon arrival to the PACU, the OR nurse/Anesthesiologist will give report to the PACU nurse to assure continuity of care.

Effective Date: ~~03/29/16~~

APPROVED:

Medical Executive Comm.: ~~03/10/16~~

Board Of Directors: ~~03/29/16~~

(12) Clinical Services
Inpatient Units:
Discharge of Patient from OR to the Post Anesthesia Recovery Unit (PACU)
12-3107

D. The RN will complete all other necessary documentation about the patient prior to leaving the PACU.

DOCUMENTATION
The OR nurse will document on the intra-operative record, implant log (when applicable), tissue log (when applicable), medication and IV sheets, OR Log and OR charge sheets as needed.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Discharge of Patient from OR to the Post Anesthesia Recovery Unit (PACU)
Descriptive Type:	~~New~~ Revised Policy
Document Number:	12-3107
Attachments:	None
Author:	David MacDonald
Typist:	Maritza Sevillano~~/Melissa Arend~~
Creation Date:	02/22/16
Revision Date:	~~N/A~~ 3/7/18
Prev. Dist. Date:	N/A

Committee Review and Approval:	Approval Date:	Comments:
Surgery Committee	~~02/24/16~~	
MEC	~~03/10/16~~	
Board of Directors	~~03/29/16~~	

Effective Date:	~~03/29/16~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: ~~Maintenance~~ Engineering Department, Clinical Services and Environmental Services

FROM: Administration

SUBJECT: **High Efficiency Particulate Air (**HEPA) Unit Setup and Removal

PURPOSE: To provide staff with a procedure to install and remove HEPA air filtration unit for patient use.

PROCEDURE:

A. **INSTALLATION OF UNIT**

1. Nursing to advise ~~maintenance~~ engineering staff when HEPA unit is needed in patient room.

2. ~~Maintenance~~ Engineering staff will install unit in required area as per nursing staff and use appropriate particulate respirator and other protective equipment, as required due to patient condition.

3. During setup of the unit, negative airflow check will be conducted by ~~maintenance~~ engineering personnel to assure that unit is working properly.

4. The order to be placed in the electronic medical record.

5. Daily Engineering checks refer to policy 22-1005 Utility Management.

B. **UNIT REMOVAL**

Upon notification from nursing that unit is no longer necessary:

1. Unit will be cleaned by Environmental Services staff with hospital approved germicidal agent.

Effective Date: ~~07/25/13~~

(12) Clinical Services
Bio-Medical Service
Hepa-Unit Setup and Removal
12-5001

Approved:

Medical Executive Comm.:

Board of Directors: ~~07/24/13~~

2. The HEPA unit will remain in the patient's room or Bronchoscopy room for at least one (1) hour, prior to being removed by ~~maintenance~~ Engineering staff.

3. Intake filter will be removed and cleaned in a non-common open area.

4. Unit will be stored in the Engineering department until next use.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: HEPA Unit Setup and Removal

Descriptive Type: Revised

Document Number: 12-5001

Attachments: None

Author: ~~Jeff Cleek~~Lionel Machado/Andrea Carrasco/Ena Menezes

Typist: Andrea Carrasco~~Jennifer Bridges~~

Creation Date: 08/20/08

Revision Date 01/25/18

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
Safety (Environment of Care) Committee	~~06/20/13~~	
Board of Directors	~~07/24/13~~	

Effective Date: ~~07/25/13~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Materials Management, Biomed and Engineering ~~and Maintenance~~

FROM: Administration

SUBJECT: Inventory and Inspection of New Clinical Equipment

Depending on the type of equipment, Biomedical Department and/or Engineering Department will take all necessary safety precautions when new equipment is being considered for purchase or is being delivered to the facility. All new equipment will be inventoried and inspected prior to it's first use on a facility patient. This policy will include all equipment within the responsibility of the Biomedical Department or the Engineering Department. New equipment that fails electrical safety tests shall not be approved for use until the deficiencies have been corrected by the manufacturer or selling agency.

PROCEDURE:

Upon receipt of any new equipment, but prior to it's installation or setup, it must be inspected for completeness of the order and condition of the equipment. Electrical and mechanical tests will be performed and the determination by the Biomedical Electronics Department will be made that the device is sound and meets safety standards. After passing the inspection, the equipment is assigned an identification number, is placed on the Addition to Equipment Management Inventory List and is assigned a preventative maintenance schedule.

When the equipment is assigned an identification number, the technician performing the inspection will document the inspection and the date of the inspection in the comments section of the equipment form.
If the equipment fails to meet or pass the required tests and inspections, the engineer will return the equipment to the manufacturer or selling agent until the deficiency is corrected. The equipment is not assigned an identification number until the equipment has passed all the requirements and is accepted by the facility.

Effective Date: ~~07/25/13~~

(12) Clinical Services
Bio-Medical Electronics Services
Inventory and Inspection of New Clinical Equipment
12-5003

Approved:

Medical Executive Comm.:

Board of Directors: ~~07/24/13~~

In the event that equipment is brought into the facility that does not belong to the facility for use (evaluation, physician owned, patient owned, leased, rental or loaner), they must be inspected and determined safe for use by the Biomedical and/or Engineering Department. The Director of Engineering is authorized to remove any item, which is found to be unsafe for its intended use in the facility.

Any equipment found to be operating in the facility that does not have a current identification tag and an inspection sticker for safety will be removed from use immediately and until scheduled inspections may be performed on said equipment or devices.

It shall be the responsibility of the Biomedical Department to routinely inspect all pertinent facility equipment and devices to determine their safe operation. If deficiencies are found, equipment will be taken out of operation and the head of the effected department will be notified and corrective measures will be implemented.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Inventory and Inspection of New Clinical Equipment

Descriptive Type: Revised

Document Number: 12-5003

Attachments: None

Author: ~~Christopher Zambrano~~Lionel Machado

Typist: ~~Jennifer Bridges~~Lionel Machado

Creation Date: 03/11/2013

Revised: 4/12/18

Prev. Dist. Date: 01/04/2007

Committee Review and Approval:	Approval Date:	Comments:
Safety (Environment of Care)~~-~~ Committee	~~06/20/13~~	
Board of Directors	~~07/24/13~~	

Effective Date: ~~07/25/13~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE DISTRICT HOSPITAL

POLICY/GUIDELINE MANUAL

TO: Clinical Services, Materials Management and Maintenance

FROM: Administration

SUBJECT: Contract Service

DELETE

POLICY:

It shall be determined that contract service for a particular piece of equipment or group of equipment units is the most cost effective and desirable method of service coverage. The type of service contract shall be investigated and all options shall be reviewed. The investigation, evaluation and comparisons shall be accomplished by the Biomedical Technician with the approval of the Chief Nursing Officer in conjunction with the Chief Financial Officer.

All aspects of the contract coverage and effectiveness including but not limited to contract coverage and contract completion shall be monitored by the Biomedical Electronics.

Contract vendor performance shall be monitored and evaluated on an ongoing basis.

The type of contract which will best serve the desired results of the facility will be evaluated and all vendors capable of performing these tasks will be asked to bid on the said coverage.

PROCEDURE:

Types of contracts:

1. Full Coverage Contracts shall be considered contracts, which include both unscheduled (emergency repair) and scheduled (preventative maintenance) maintenance. This type of coverage will involve the least amount of work for the operator and the Biomedical Electronics, as it will be up to the vendor to accomplish all maintenance of the equipment. The time invested in the management of the contract will involve the most effort by the Biomedical Electronics as the billing will have to be monitored and the contract will need to be overseen to insure that all provisions of the contract(s) is being carried out in a timely manner.

2. Unscheduled Maintenance Only (emergency repair) Contracts are desirable where the ability to perform the scheduled preventative maintenance program exists within the Tulare Local Healthcare District. Each piece of equipment shall receive a minimum of one preventative maintenance inspection per year.

3. Scheduled Maintenance Only (preventative maintenance inspection) Contracts shall be considered cost effective where the need for expensive specialized test equipment is needed and is not owned by Tulare Local Healthcare District. Where the reliability of the equipment is such that the unscheduled down time of the equipment does not warrant the need for full coverage. Cost effectiveness shall be a major part in this decision.

4. Parts Only Contracts shall be considered where the expertise to perform the work required is contained within the facility but the cost of parts is expensive. The decision to acquire this type of contract shall be supported by documentation to the cost of parts and the capability of the Biomedical Electronics staff.

Variations of and combinations of the aforementioned are another possibility. Where documentation is present, it is possible to decide the most cost effective method of coverage for each piece of equipment. The extent of coverage and any portion of the workload which can be performed by the in house personnel shall be prime considerations to the exact type of coverage required.

Items to be considered:

Parts availability for the effective repair of the equipment in question is a prime consideration. Not only can the vendor acquire the needed parts but are the needed parts available within a reasonable amount of time. Is the responsibility of getting the parts within a certain amount of time within the contract? Is the shipping cost of parts covered by the contract? In a "Parts Only" contract, is the facility to be charged for the troubleshooting time involved if the parts are not available and more than one service visit is required, or are you to be charged only for the repair time involved?

Miscellaneous expenses such as parking, meals, accommodations, tolls, mileage and travel time shall be investigated in advance as to whether they are covered in the contract or not. If not, this may become a point of negotiation.

What specific items, if any, will be excluded from the coverage? In many contracts the more expensive parts are exclude from the parts coverage. These items shall be stated specifically or negotiated into the pricing and included.

Cancellation/termination capability of the facility and/or vendor shall be stated specifically in the contract. The wording "without cause" shall be included and the terms shall be a 30 day written notice. This will allow termination of the contract should the coverage be less than or of inadequate quality from what is agreed upon at the onset. Keep in mind that the same applies to the vendor, should they require cancellation for whatever reason. Should this occur, immediate steps shall be taken to secure coverage elsewhere which will start on the cancellation date of this contract.

Cost and contract term shall be clearly stated. Guaranteed renewal cost shall be included wherever possible. Multi year or multi term contracts shall have the price for each year or term negotiated in advance.

Performance guarantees shall be stated in the terms of the contract. This can be in the form of guaranteed uptime percentages, minimum response time guarantees, parts availability etc.

Considerations and Service Provider Requirements:

General Liability, Automobile Liability and Worker's Compensation certificates shall be acquired from each vendor that is under contract to do work in the facility. These certificates shall contain provisions where by the coverage may not be canceled or restrictive modifications can not be made during the term of the contract or unless a 30 day written notice has been given to the facility either in person or by registered mail. The facility shall be named as an additional added insured to these policies in regard to any claims that may arise under the contract.

The service provider shall provide this facility with the name of the primary service technician/engineer and the geographic area of his coverage. The backup coverage for this service provider shall be stated and the qualifications of the primary and secondary service person shall be supplied.

Additional Information Required:

1. Size and diversity of the service provider
2. Years in business in the geographic area
3. Normal service hours of the service provider
4. Capabilities of extended hour coverage
5. Experience with the facility in providing service
6. Response time: by telephone and on sight
7. Parts depots: nearest location, backup location, factory backup
8. Availability of loaner equipment and cost
9. Availability of specialized test equipment and calibration documentation
10. Availability of service documentation
11. Availability of competent technical support

Surveys shall be taken to determine what other facilities are paying for the same coverage on similar equipment. Name or names of people with the service provider capable of negotiating contract or service problem cost and terms. Name of the service manager or director with the service provider.

Service Contract Cost Effectiveness Analysis:

The cost effectiveness shall be evaluated annually. The total cost of service and parts provided shall be added to the travel time and miscellaneous expenses for the contract. This shall be compared to the non-contract cost for the same service. This assessment shall be made with the total cost of the service provider's competition as well when possible. If there is an increase in the contract cost for the following year, you will acquire contract price quotations from acceptable competitors prior to continuing with the service contract.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Contract Service
Descriptive Type:	Revised
Document Number:	12-5004
Attachments:	None
Author:	Daniel Esparza/Paula I. Richards
Typist:	Julie Gresham
Creation Date:	12/1/04
Prev. Dist. Date:	02/27/02
Revision Notes:	MEC 05/10/06 General Board 05/24/06
Effective Date:	05/25/06
Forward To:	Policy Binders = 5 and Post to Intranet site
Disposition:	Copy and Distribution – Administration
Comments:	

Policy # 12-5004

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Speakers Bureau Guidelines

I. PURPOSE

To establish a centralized and coordinated process for disseminating information through public speaking presentations. The TLHD Marketing Department will facilitate and coordinate public speaking requests, requests regarding health education classes will be referred to the TLHD Educational Services Department or other sponsoring departments, as appropriate.

II. SPEAKER QUALIFICATIONS

Tulare Regional Medical Center Medical Staff members will always be recruited to present healthcare information by area of training. Tulare Regional Medical Center Staff will not dispense medical information without physician representation during the presentation.

Qualifications of speakers shall include group dynamics and public speaking skills, as well as the following criteria:

A. Motivated, dynamic individual who represents the health care system well.

B. Possess current knowledge and skills in the subject matter.

C. Ability to present, using audience appropriate terminology to explain medical terms, procedures, or other concepts when necessary.

D. Ability to speak audibly and clearly.

E. Communicate effectively in the audience's primary language.

F. Ability to use audio-visual aids and handouts as learning tools if appropriate.

Effective Date: ~~07/26/12~~

APPROVED:

Board of Directors: ~~07/25/12~~

(13) Ancillary Services/Administration
Community Relations/General:
Speaker's Bureau Guidelines
13-11,001

III. **CONFIRMATION**

The Marketing Department will communicate with the speaker and the requester and provide electronic documentation of presentation location, time, target audience and estimated number of attendees.

The Marketing Director or member of Administration will attend the presentation to ensure audio visual equipment is functioning and hand outs are presented for distribution.

IV. **FEE STRUCTURE**

Administration will review and respond to each request for special speaking fees as they occur.

Speaker Honorariums and gifts for hospital employees shall be given to Tulare Local Health Care District or Tulare Hospital Foundation rather than the individual speaker.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces or supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Speakers Bureau Guidelines
Descriptive Type:	Revised
Document Number:	13-11,001
Attachments:	None
Author:	~~Sherrie Bakke/~~Sherrie Bakke/~~Andrea Carrasco/Ena Menezes~~
Typist:	~~Sherrie Bakke/Gillian Busch~~Andrea Carrasco/Ena Menezes
Creation Date:	02/25/06
Revision Date:	01/25/18
Prev. Dist. Date:	03/30/06

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~07/25/12~~	

Effective Date:	~~07/26/12~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: Director of Marketing/Public Information Officer Responsibilities and Guidelines

PURPOSE:

Every Department Director/Manager has a unique and individual responsibility for the public relations aspects of their department as it affects the whole health care system. Coordinating Tulare Regional Medical Center Public Information activities including media contacts, advertising, speaker's bureau, publications, foundation/fundraising, as well as lending public relations support to department managers is the responsibility of the Marketing Department /Public Information Officer.

The Marketing Department is also responsible for developing an annual marketing plan in coordination with Administration, to support the strategic direction of Tulare Regional Medical Center reflective of the Mission, Vision and Values of the District.

ACCOUNTABILITY:

All health care system news information and publications are coordinated for distribution by the Marketing Department. The Marketing Director reports directly to ~~the Vice President of Business Development~~Administration.

I. **MEDIA RELATIONS**

The Marketing Department will be the primary relationship manager for all media outlets. All Media Releases will be distributed by the Marketing Department. When appropriate the Marketing Department will assist department directors in preparing information for interviews and press conferences. The Marketing Department will provide counsel in the handling of public information matters.

The Director of Marketing, as directed by Administration, may serve as official spokesperson for the District. Continued credibility and integrity with the media

requires the department be known for accuracy, honesty, clarity of information and timely response.

Every effort shall be made to contact the Marketing Director at the office, by cellular devise, email or home in the event of any media contact with TRMC for any reason. In the event of the Director's unavailability, contact should be made with the Administrator on Call.

Should an exchange of information take place between TRMC and the media in the absence of the Marketing Director or Administrator, every effort will be made to inform the Marketing Department as to the with whom discussed and subject discussed.

The Marketing Department has the obligation to exercise editorial judgment regarding the form and content of materials distributed. This is not an attempt to abridge the freedom of any individual to express their personal views. The department's aim is to assure materials distributed, internally and externally are properly branded and meet the editorial content style reflective of the Mission, Vision and Values of Tulare Regional Medical Center.

A. **Release of Patient Information to the News Media**

To enable uniformity and continuity of the release of patient information and to ensure the protection of patient's rights while at Tulare Regional Medical Center, all media inquiries must be directed to the Marketing Department. The Marketing Director may, at Administration's his/her discretion and unless otherwise requested by the patient, next of kin or physician, (by the completion of the No Information Patient form as listed in Tulare Regional Medical Center Policy #13-9001), obtain and release any or all of the specific patient information to the news media, as listed in this policy using the Exhibit "Authorization for use or disclosure of Protected Health Information for Marketing and/or Media Release."

B. **Unsolicited Media Contacts by Radio, Television or Newspapers**

Approval of the Director of Marketing or Administration must be obtained prior to any staff contact with the media. For example: If a reporter contacts any TRMC staff member, the reporter must be referred to the Marketing Department or Administration. The Director will then screen the request and arrange for an appropriate response in consultation with Administration.

Any written material planned for release to the media must be approved by Administration and a copy of the material provided to the Marketing Department for final editing and distribution.

C. **Solicited Information for the News Media**

All solicited information for the news media **(except patient information, see "A" above)** is to be approved by Marketing in consultation with Administration

For media contact initiated by the Marketing Department, the following steps should be:

1. Marketing Department contacts appropriate Department Director to inform them of content of release.

2. Marketing Department will designate appropriate contact person and coordinate scheduling with media personnel.

3. Marketing Department notifies appropriate Department Director of details of interview, photographs, filming, etc.

4. Contact person refers any negative responses, questions, complaints, etc., to the Marketing Director or Administration for follow-up with media.

5. When a representative from the Marketing Department is not available, the staff member who initiates the contact with the media will be responsible for obtaining required consent or approvals from Administration.

D. **Photography, Video, Electronic or Audio Media**

Our goal is to protect our patient's privacy. However, there are instances where the use of photography or digital recording for external marketing purposes may enhance our message. Prior to any filming, the following steps should be:

1. Prior consent of the Marketing Director and/or Administration must be obtained for any solicited photography from an outside source. Anyone who engages in recording or filming, not already bound by the hospital's confidentiality policy, must sign the Tulare Regional Medical Center Confidentiality Statement prior to filming, to protect the patient's identity and confidential information. When such consent is granted, the area Clinical Director must be notified in advance.

2. When photography is initiated by the Marketing Department, or Administration, appropriate hospital Directors will be notified in advance.

3. If photography or filming will include patients currently admitted, the attending physician or appropriate Department Director will be notified in advance in order to establish appropriateness and to coordinate with patient's medical care.

4. **At no time shall the photographing of a patient be authorized unless the consent of the patient or responsible person has been obtained.** (See attached "Photo, Video, Name Release" Authorization and Consent form)

5. Patients may request cessation of recording, filming or photography anytime during the photography session.

6. Patients also have the right to rescind consent for use of any images up to a reasonable time before the recording, photo or film is scheduled to be released.

E. **Disaster/Crisis/Controversial Communication**

The Marketing Director will report to the Command Center as the Public Information Officer (PIO) to determine the extent of public relations involvement needed, following the HICS guidelines Refer to Policy #21-2013 Media Communications During a Disaster.

II. PUBLICATIONS/ADVERTISING

A. Brochures/Printed Materials

The Marketing Department is responsible for all the approval of all internal and external printed and website material for Tulare Regional Medical Center, including but not limited to:

1. Forms

2. Hospital and Department Sell Sheets, Brochures and Flyers

3. Community Newsletters

4. Novelties/Giveaways

Publication procedures include planning, content preparation and production. Public Information Department will assist with the overall strategic planning regarding target audience, timing, and impact on hospital public relations in the community. Public Information will discuss copy emphasis with Department Manager, before initial drafts are attempted. The artwork/photos, logo usage, colors and layout style should be discussed before final draft of design, with the Director of Public Information. Administration will have final approval.

B. **Advertising**

All advertising for available hospital positions will be placed by the Director of Human Resources.

Other hospital advertising in any print vehicle such as newspapers, magazines, billboards, signs, newsletters, directories, telephone directories, and any electronic media shall be placed by the Marketing Department with the approval of Administration.

III. FORMS AND BUSINESS CARDS

All Tulare Regional Medical Center business cards and forms shall be coordinated through the Materials Management Department. If there is a major change required, forms must be presented to the Forms Committee the Marketing Department will approve the branding of all Forms and then processed through Materials Management Department.

IV. LOGO USAGE

Tulare Regional Medical Center has a corporate logo usage guide to ensure the accurate and consistent branding of Tulare Regional Medical Center and its services. The Logo Usage Guide can be found on the Intranet in the Marketing Files.

V. SPEAKERS BUREAU

See Speaker's Bureau Guidelines policy #13-11,001.

VI. PHYSICIAN REFERRAL

In accordance with STARK Laws, Tulare Local Healthcare District subcontracts with a professional referral service and provides no direct physician referrals to patients or community members. For more information refer to Policy # 10-1002.9 Physician Referral and Kickback Policy and Procedure.

VII. LEGISLATIVE ISSUES

Questions concerning legislative issues or contacts should be referred to TRMC Administration.

VIII. TULARE HOSPITAL FOUNDATION

Tulare Hospital Foundation is a separate 501 C3 not for profit organization. The mission of Tulare Hospital Foundation is to secure philanthropic support for Tulare Regional Medical center, enhancing medical services and bringing healing comfort and high quality care to the people it serves..

All donations to TRMC and fundraising efforts will be coordinated by Tulare Hospital Foundation office.

Fundraising contacts are often in various stages of development and require coordination. Although employees of the hospital can be very beneficial in assisting in various ways, it is important all fundraising be coordinated with Tulare Hospital Foundation office, in order to assure proper relationship management, donor acknowledgement and tracking.

Tulare Regional Medical Center Chief Executive Officer will request funding from Tulare Hospital Foundation based on the hospitals strategic and in accordance with the Mission of the Foundation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION FOR
MARKETING AND/OR MEDIA RELEASE

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name of Patient:_____ Date of Birth:_____

Other Names Used: _____Telephone Number: _____

Medical Record or Account#:_____
(Hospital use only)

I AUTHORIZE: _____
(Facility or other provider)

TO DISCLOSE TO: _____
(Persons/organizations authorized to ***receive*** the information)

at the following address:_____
(street, city, state and zip code)

the following information (check all applicable boxes below):

This authorization permits use and/or disclosure of the following information about the patient:

- ☐ photo
- ☐ video and digital/ audio recording
- ☐ name, age, address, location
- ☐ diagnosis data
- ☐ treatment or physical condition
- ☐ outcome
- ☐ test results and diagnostic reports
- ☐ background, work, family
- ☐ Other Information: _____

PURPOSE: The purpose of the requested use or disclosure is:

- ☐ TRMC media stories
- ☐ Marketing communications to patient
- ☐ at the request of the patient or personal representative
- ☐ use in TRMC Marketing Materials
- ☐ use in TRMC newsletters
- ☐ Others:

_____

MY RIGHTS:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address*:869 N. Cherry St. Tulare CA 93274 attn Marketing Department*. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). If this authorization is for the disclosure of substance abuse information, the recipient may be prohibited from disclosing the information under 42 C.F.R. part 2.

SIGNATURE:

_____Date:_____
(Patient or personal representative)

_____
Print name of personal representative Relationship to patient

Patient/Representative Identification Verified. *Initials:*_____ *Dept:*_____

[1]

Note: If the **substance abuse treatment** information is protected by federal confidentiality rules (42 C.F.R. part 2) the following prohibition of re-disclosure statements must be provided to the recipient of the information:

The federal rules prohibit the recipient from making any further disclosure of the information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

[1] This statement is required to be sent with disclosures of substance abuse information subject to 42 C.F.R. part 2 (see Use and Disclosure of Mental Health, Developmental Disability and Substance Abuse PHI policy 9.826 for additional information). The required statement can be included on a copy of the authorization sent with the disclosure, or it may appear as a stamp or label attached to the records containing the protected PHI.

Tulare Regional Medical Center

AUTORIZACIÓN PARA USO Y REVELACIÓN DE
INFORMACIÓN DE SALUD PROTEGIDA PARA
MERCADEO Y/O COMUNICADOS DE PRENSA

Al completar este documento se autoriza la revelación o el uso de información sobre su salud. El hecho de que no se proporcione *toda* la información solicitada puede invalidar esta autorización.

USO Y REVELACIÓN DE LA INFORMACIÓN DE SALUD PROTEGIDA:

Nombre del paciente: _____ Fecha de nacimiento:_____

Otros nombres: _____Número de teléfono: _____

Número de historia clínica o de cuenta: _____
(Para uso exclusivo del hospital)

YO AUTORIZO A: _____
(Institución u otro proveedor)

A REVELAR A: _____
(Personas/organizaciones autorizadas a ***recibir*** la información)

en el domicilio siguiente: _____
(calle, ciudad, estado y código postal)

la información siguiente (seleccione todos los casilleros a continuación que correspondan):

Esta autorización permite el uso y/o la revelación de la siguiente información sobre el paciente:

- ❑ foto
- ❑ vídeo y grabación digital/audio
- ❑ nombre, edad, domicilio, ubicación
- ❑ datos diagnósticos
- ❑ tratamiento o condición física
- ❑ resultado
- ❑ resultados de los análisis e informes diagnósticos
- ❑ antecedentes, trabajo, familia

❑ Otra información:_____

PROPÓSITO: El propósito del uso o de la revelación solicitada es:

- ❑ relatos de TRMC a los medios.
- ❑ comunicaciones promocionales para el paciente
- ❑ uso en materiales comerciales de TRMC
- ❑ uso en boletines de TRMC

❑ a pedido del paciente o del representante personal

❑ Otros: _____

MIS DERECHOS:

- Puedo negarme a firmar esta autorización. Mi negación no afectará mi habilidad de obtener el tratamiento o de pagar, o mi elegibilidad para recibir beneficios.
- Puedo revocar esta autorización en cualquier momento, pero debo hacerlo por escrito, y enviar dicha revocación al siguiente domicilio: *869 N. Cherry St. Tulare CA 93274 attn Marketing Department.* Mi revocación entrará en vigor al momento en que sea recibida, salvo en la medida que terceros hayan actuado basándose en esta autorización.
- Tengo derecho a recibir una copia de esta autorización.

La información revelada como resultado de esta autorización podría ser revelada reiteradamente por el receptor de la misma. En algunos casos, tal reiteración de la revelación podría no estar protegida por las leyes de California y podría dejar de estar protegida por la ley de confidencialidad federal (HIPAA, por su sigla en inglés). Si esta autorización es para la revelación de información relacionada con el abuso de sustancias, es posible que el receptor tenga prohibido revelar esta información en virtud de la 42 C.F.R., parte 2.

FIRMA: _____ Fecha: _____
(Paciente o representante personal)

_____
_____
Escriba el nombre del representante personal en letra de imprenta Relación con el paciente

Se verificó la identificación del paciente/representante. *Iniciales*:_____ Departamento:_____

1
Nota: Si la información sobre el **tratamiento para el abuso de sustancias** está protegida por las normas de confidencialidad federales (42 C.F.R. parte 2) se deberá proporcionar las siguientes declaraciones para la revelación reiterada al receptor de la información:

Las normas federales prohíben que el receptor realice cualquier otra revelación de la información a menos que dicha revelación adicional se encuentre expresamente autorizada en el consentimiento por escrito por la persona a la cual pertenece, o de cualquier otra forma permitida por la 42 C.F.R. parte 2. Una autorización general para la liberación de información médica o de otra índole NO es suficiente para ello. Las normas federales restringen todo uso de la información para investigar penalmente o para interponer una acción judicial a cualquier paciente alcohólico o drogadicto.

[1] Esta declaración deberá enviarse junto con la revelación de información de abuso de sustancias en virtud de la 42 C.F.R. parte 2 (véase la norma 9.8126 sobre Uso y Revelación de Información de Salud Protegida sobre Salud Mental, Incapacidad de Desarrollo y Abuso de Sustancias si desea obtener más información). La declaración requerida podrá incluirse en una copia de la autorización enviada junto con la revelación, o puede aparecer como un sello o una etiqueta adherida a la historia clínica que contiene información de salud protegida.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTERTDH

POLICY/GUIDELINE MANUAL

Descriptive Name: Public Information Responsibilities and Guidelines

Descriptive Type: Revised Policy

Document Number: 13-11,003

Attachments: Marketing and/Or Media Release (also available in Spanish)

Author: ~~Sherrie Bakke/~~Andrea Carrasco/Ena Menezes

Typist: ~~Sherrie Bakke~~Andrea Carrasco

Creation Date: 06/25/09

Revision Date: 01/25/18

Prev. Dist. Date: 09/23/09

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~07/25/12~~	

Effective Date: ~~07/26/12~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Request for Interviews, Videotaping and Photography

I. PURPOSE:

The purpose of this policy is to assure that the privacy and confidentiality of staff, patients, and/or patient families are given the highest priority with regard to media requests for interviews, videotaping or photography.

II. POLICY:

A. To effectively facilitate media requests, Tulare Regional Medical Center has established the following guidelines:

1. Members of the media interested in conducting interviews, taking video or photographs of staff, patients or patient families or friends, **must** contact the Marketing Department for authorization.
2. A member of the Marketing Department or a District~~hospital~~ designee will accompany members of the media at all times while on District~~hospital~~ property.
3. All patients, patient family members, friends, and district~~hospital~~ staff must sign Tulare Regional Medical Center's consent form before the media will be allowed to interview, photograph or videotape.

III. INTERVIEW OR PHOTOGRAPHY OF PATIENTS, PATIENT FAMILIES and FRIENDS, TRMC STAFF/REPRESENTATIVE:

A. All request to interview and/or photograph (still or video) patients or family and/or friends of patients while on district~~hospital~~ property must be made to the Marketing Department. Staff members should notify the Marketing Department regardless of where the interview or photography will take place.

B. **Only** the Marketing Department or designee may grant the media access to patients, patient families and friends, and staff. The department or designee will make the contacts and arrangements necessary for

interaction with the media. No images may be taken or interviews completed without authorization and direction from the Marketing Department.

C. The physician or districthospital may choose not to make inquiries regarding media requests of patients, or patient families/friends, or staff if it is deemed doing so would have an adverse effect upon a patient's condition, other patients might be negatively affected or if there are other circumstances the districthospital determines unfavorable.

IV. DOCUMENTATION

A. Appropriate authorized consent to photograph or release information form must be completed prior to interview or photograph (still or video).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Request for Interviews, Videotaping and Photography

Descriptive Type: ~~New Policy~~Revised

Document Number: 13-11,006

Attachments: None

Author: ~~Viktoria Meyers/~~ Viktoria Meyers /~~Andrea Carrasco/Ena Menezes~~

Typist: ~~Julie Gresham~~Andrea Carrasco/Ena Menezes

Creation Date: 06/14/10

Revision Date: ~~-~~01/25/18

Prev. Dist. Date: 06/24/10~~None~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~06/23/10~~	

Effective Date: ~~06/24/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Tulare Hospital Foundation Donor Recognition

PURPOSE: This policy contains guidelines for granting the honor of naming hospital assets for both philanthropic and other distinguished support. It sets out a consistent approach to the naming of Facilities, Major Equipment, Programs and other components of its operation.

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INTRODUCTION: The Mission of Tulare Regional Medical Center is fulfilled, in part by the support it receives from volunteers and philanthropic gifts. Plaques and monuments have been placed in selected locations throughout facilities of Tulare Local Healthcare District to recognize the generous support from contributors. These recognition items are often not considered during construction and renovation. In order to address recognition for gifts supporting construction, renovation, or equipment acquisitions, the following policy will be observed whenever appropriate.

PROCEDURE: The philanthropic services and programs provided to the hospital are the responsibility of the Tulare Hospital Foundation.

1. Tulare Regional Medical Center retains the sole right to name its assets and will name assets only as it deems appropriate.

2. In the process of naming assets, Tulare Regional Medical Center shall consider factors affecting the hospital's reputation and reserves the right to withdraw naming rights at its sole discretion.

3. Permanent named recognition will be provided only in circumstances where gift size and/or contribution to the organization are exceptional. When permanent named recognition has been extended for a gift received, it will be honored in perpetuity. (This does not negate the hospital's authority as noted under item 2.) In the event of changed circumstances, e.g. a facility no longer exists or has been radically renovated, the hospital reserves the right to determine the form of permanence.

4. Only in exceptional circumstances will assets be named to honor outstanding service of members of staff, the Board of Directors of the hospital, the Foundation,

any elected or appointed official concerned with the functions or control of the District so long as their official relationship continues. However, such individuals making philanthropic donations remain eligible for naming recognition.

5. Naming shall not be bestowed in honor of any individual, group or organization linked to causes that could compromise health, the Mission, Vision or Values of Tulare Regional Medical Center or the well being of its staff, physicians, volunteers or patients it serves.

6. Prior to naming an asset, consideration shall be given to its full potential to generate revenue as donor naming opportunity while balancing other benefits and the current philanthropic environment.

7. No name will be approved implying the hospital's endorsement of a partisan political or ideological position or of a commercial product. This does not preclude naming recognizing an individual or company manufacturing or distributing commercial products.

8. Provisions in this policy also generally apply to naming for a benefactor or naming for a third party at the wish of a benefactor.

9. The Foundation will be notified whenever any plaque or donated item bearing a plaque or inscription needs to be moved.

Authority:

- The Tulare Hospital Foundation will establish giving levels and any other criteria to be used to determine appropriate recognition of donors in conjunction with the Tulare Regional Medical Center Chief Executive Officer and Chairman of the Board.

- Tulare Regional Medical Center, shall, as appropriate, entertain proposals for recognition from and in consultation with the community, Tulare Hospital Foundation, TRMC Medical Staff, Administration and Employees and major corporate partners. Recommendations are to be directed to the Chairman and President of the Tulare Regional Medical Center Board of Directors and addressed in the care of the Chief Executive Officer.

- The hospital reserves the right to decide on the nature of physical displays which may accompany named recognition while recognizing the value of donor or honoree input.

- Tulare Hospital Foundation will maintain a comprehensive record of all plaques, memorials, and other named items or facilities. These will be reviewed regularly to be certain donors are appropriately recognized and commemorative items are

returned to their proper location whenever remodeling or redecorating causes their removal.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Tulare Hospital Foundation Donor Recognition

Descriptive Type: Revised~~New Policy~~

Document Number: 13-11,007

Attachments: None

Author: Sherrie Bakke/Andrea Carrasco/Ena Menezes

Typist: Sherrie Bakke

Creation Date: 07/18/12

Revision Date: 01/25/18

Prev. Dist. Date: 02/28/13~~None~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~02/27/13~~	

Effective Date: ~~02/28/13~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE MANUAL

TO: All Departments

FROM: Administration

SUBJECT: New Employee Orientation Program (General Orientation)

The General Orientation Program introduces all new employees to the facility. This program consists of one (1) day from 8:00 a.m. to 3:30 p.m. and is *mandatory prior to beginning in work area. It is offered once a month (the first Monday). Employee attendance is arranged through Human Resources and coordinated through the Educational Services Department.

This comprehensive orientation program is designed by the Educational Services Department, Human Resources, and Department Managers to provide each new employee a basic understanding of the facility and the team he/she belongs to.

Content for the program is based on the following criteria:

1. External standards/requirements.

2. Essential information that applies to all staff.

3. Mandatory internal requirements.

4. Employee must have information prior to starting work.

The programs are continually evaluated for effectiveness and appropriateness through quality assessment and improvement activities.

Proof orientation has been completed will be submitted to Department Managers and Human Resources. If an employee has terminated employment and returns after 6 months, they will repeat General Orientation.

*If extenuating circumstances occur that change the usual attendance of General Orientation, Human Resources will be contacted for approval (exception- nursing approval will be through Nursing Administration in communication with HR). If approved, one of two alternatives will be followed:

1. Delay in Attending General Orientation (G.O.)

When it is necessary to start an employee prior to G.O., the following steps are to be taken:

a. Obtain a packet (*Appendix A* - Module #1) from HR or Education and be scheduled for the next G.O.

b. Employee's manager will cover items listed on form and return it to HR within 2 working days.

c. Employee will attend G.O within 1 month of hire.

d. Nursing employees will need to be scheduled (prior to working with patients) for clinical orientation with education.

2. Hardship in Attending or Travelers/Temps/Volunteers/Students

When an employee has full time work commitments elsewhere and is unable to attend any General Orientation session as in the case of part time or on call employees; or when employees are here for a limited time, as in the case of Travelers and Temps (or others that have limited roles, as in volunteers or students) the following steps will be taken to provide the information they need:

a. Obtain a packet (*Appendix B* - Module #2 Fast Path) from HR or Education.

b. The manager will cover items listed on the Fast Path form with the new employee prior to the first day worked and return the signed form to HR within 2 working days. ~~The employee will also be scheduled to view the Compliance Training video with Education within (30) days of new hire.~~

c. Should the individual upgrade to full time status or become a permanent employee they will attend the next scheduled General Orientation Session.

d. Nursing employees will need to be scheduled (prior to working with patients) for clinical orientation with education.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Appendix A

NEW EMPLOYEE GENERAL ORIENTATION
MODULE #1 / DELAY

Who: A New Hire asked to start their new position prior to the next scheduled General Orientation.

Purpose: For those who cannot attend General Orientation Day before starting employment. The new hire employee must complete the below items in order to be compliant with requirements.

Instructions: Report directly to your supervisor on or before your first day of work to completed the following items. Return signed sheet and modules to the HR Department within 2 working days.

Must be reviewed on or before your first day of work by your supervisor.

Your General Orientation class is scheduled for:

DATE: _____ TIME: _____

		Initial Employee	Initial Supervisor
1.	Confidentiality Agreement/Associated Staff Brochure		
2.	Mission Vision & Values Policy #10-1002		
3.	Customer Service Standards Policy #10-1087		
4.	Harassment Policy ~~#15-2049~~		
5.	Safety / Disaster Policy #21-2009 & #21-2010		
6.	Dress Code Policy ~~#15-2028~~		
7.	Department Specific Safety Issues		
8.	Other Department Specifics		
9.	Clocking/Time and Attendance		
10.	Hospital Tour		
11.	Return to Human Resources Department completed paperwork		

Employee_____ **Date**_____

Supervisor_____ **Date** _____

Return this form and Associated Staff Brochure to Human Resources within two working days.

Appendix B

New Hire & Contract General Orientation
Module #2 / Fast Path

Who: Hardship/Travelers/Temps/Students (employed)

Purpose: For those who cannot attend the General Orientation Day due to hardship. The new hire employee must completed the below items in order to be compliant with requirements.

Instructions: Report to your supervisor on or before your first day of work to completed the following items. Return signed sheet to HR Department within 2 working days.

Need: Your login to access modules (Receive from Education)
(Name) First_____ Last_____ Emp#_____

Must be reviewed on or before your first day of work by your supervisor.

		Initial Employee	Supervisor
1.	**Online Modules:** Mandatory Quest**: #017, #018, #019, #020**; Documentation: Clinical **#028** or Non-Clinical **#029**; ATD: Non-clinical **#024**, Clinical **#025**, or RN, LVN, **PA #026** (Intranet Education Site) Tracker Trainer Link- http://edutracker.com/TrkTrnr/Trk_Login.aspx		
2.	~~Compliance Training DVD & handbook.~~ Quality Review Report (QRR- Verge)		
3.	Accessing Intranet Policies & Procedures (Supervisor)		
4.	Dress Code Policy ~~#15-2028~~		
5.	Clocking/API (Supervisor)		
6.	Systems Access (phone-computer-internet) Policy #11-6004		
7.	Other Department Specifics (as required) N95		
8.	Hospital Tour		

Employee_____ **Date**_____

Supervisor_____ **Date** _____

Return this form and Associated Staff Brochure to Human Resources within two working days.

Descriptive Name: New Employee Orientation Program (General Orientation)

Descriptive Type: Revised

Document Number: 13-12,003

Attachments: Two

Author: Carol Bradford

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 03/09/10

Revision Date: 01~~12~~/17~~22~~/18~~4~~

Prev. Dist. Date: ~~03/29/12~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Staff

FROM: Administration

SUBJECT: Continuing Education Programs for Clinical Nursing Staff

RN's and LVN's are required by the Board of Registered Nursing to attend thirty (30) hours of continuing education every two (2) years. In an effort to provide quality educational support for our nursing staff, the Educational Services Department provides continuing education classes. Education is a provider approved by the California Board of Registered Nursing provider number 02173.

All continuing education programs must be coordinated by the Staff Educator or designee. As the approved provider is required to accept full responsibility in assuring the compliance with all regulations related to continuing education for each course, all aspects are coordinated and approved by the Staff Educator or designee. Continuing education programs are not "contracted".

Continuing education classes organized for relicensure by the BRN require the following material (see BRN guidelines):

1. Instructional vitae of all instructors

2. Request for continuing education form, which includes:

    a. Summary

    b. Class instructors

    c. Behavioral objectives

    d. Method of teaching (optional) recommended

    e. Outline

    f. Method of evaluation (objective and subjective) recommended

    g. Record of time, date(s) and place(s) of each course held

3. A record of any **certificate of attendance** issued indicating successful completion must contain the following:

   a. Name of participant and Nurse license number

   b. Course title

   c. Provider name (as approved by the Board), address, and provider number

   d. Date of course

   e. Number of continuing education contact hours.

   f. Signature of instructor and/or provider or provider designee.

   g. The following two (2) statements MUST be printed on the certificate:

      I. "This certificate must be retained by the licensee for a period of four (4) years after the course ends".

      II. ”Provider approved by the California Board of Registered Nursing, Provider number 02173 for _____contact hours.”

   h. Certificates of completion must be issued within ninety (90) days after conclusion of the course.

COST
In as effort to provide continued support for Education Services, all facility RN’s will be charged $3.00* per contact hour, LVN’s will be charged $2.00* per contact hour, and CNA/Tech’s will be charged $1.00* per contact hour for C.E. classes. An employee may observe a class (without receiving C.E. credit) at no charge. All other outside individuals will be charged $7.00 per contact hour.

*Exceptions may be made at the discretion of the Staff Educator (i.e., outside speaker’s expense).

PRE-REGISTRATION INFORMATION
For hospital employees and outside participants pre-registration WITH PAYMENT is necessary for all classes. Classes may be cancelled one (1) day prior due to low registration.

REFUND POLICY
Refunds are available (within one month) only under the following conditions:

1. You are not accepted as a participant.

2. Sessions canceled by the Staff Educator due to unavailability of instructor, inadequate number of pre-registered participants, and/or any other reasonable indication will follow with notification of registered participants immediately concerning cancellation by phone, email or mail.

3. Notification of participant withdrawal is received at least two (2) working days prior to the scheduled class date.

4. Substitution of class participants will be allowed with two (2) working days prior notice and approval of class instructor.

5. In lieu of refund, fees paid by an individual may be held by Educational Services with the participant's approval, and applied to another class, one (1) time only.

ADVERTISING
Information disseminated by approved providers publicizing continuing education shall include the following:

1. The statement; "Provider approved by the California Board of Registered Nursing, Provider number 02173 for _____contact hours".

2. Provider's policy on refunds in case of non-attendance by the registrant or cancellation by provider.

3. A clear concise description of the course content and/or objectives.

4. Provider name as officially on file with the Board – Tulare Local Health Care District.

COMPLAINTS
1. Any complaints regarding the course can be detailed in the course Subjective evaluation and/or discussed with the Staff Educator. All evaluations are reviewed at the end of each course for possible revisions, if necessary.

OTHER DISCIPLINES
1. Respiratory Therapists may utilize BRN contact hours, providing subject is appropriate to their scope of practice.

2. A provider number from the BRN is applicable to the LVN Board, as well as Certified Nursing Assistants provided C.N.A. is indicated after the individual's name.

3. Portions of this policy could be applicable to other clinical disciplines as appropriate.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Continuing Education Programs for Clinical Nursing Staff

Descriptive Type: Revised

Document Number: 13-12,004

Attachments: None

Author: Carol Bradford

Typist: Melissa Arend

Creation Date: 09/25/08

Revision Date: 01~~12~~/17~~22~~/18~~4~~

Prev. Dist. Date: ~~06/23/11~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Program Instructor Fees

The Educational Services Department provides education programs for the purpose of maintaining and upgrading competency and skills of facility staff. Outside instructors are from time to time used to accomplish the above. Payment requirements for these instructors shall be coordinated through the Educational Services Department. Payment agreement for instructor shall be completed and approved prior to conducting the course and shall be made to instructors for actual class time only.

Payment shall not be made for preparation time.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Program Instructor Fees

Descriptive Type: Revised

Document Number: 13-12,005

Attachments: None

Author: Carol Bradford

Typist: Melissa Arend

Creation Date: 09/25/08

Revision Date: 01~~12~~/17~~22~~/18~~4~~

Prev. Dist. Date: ~~06/23/11~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Educational Services Department Hard and Software Rental

1. The request for such items will be made in advance of at least one (1) week, preferably one (1) month.

2. Any items will be loaned at the discretion of the Educational Services Department staff and a fee will be decided upon at that time.

3. The equipment will be returned in the same condition in which it was loaned. All repairs (if need to be done) or replacements will be completed at the cost of the borrowing facility.

4. The following attachment will be signed by the borrower:

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

RENTAL AGREEMENT

I, _____, representing _____ facility agree to all the conditions below in renting the following items:

1. _____
2. _____
3. _____
4. _____

1. Above item(s) rented from _____ and returned to Tulare Regional Medical Center (TRMC), Educational Services Department on _____
2. Item will be returned in the same condition in which it was borrowed. Comments on condition prior to rental:

_____

_____

_____

3. Any item retained longer than the above date (without permission of the Educational Services Department) will be charged the weekly rate until returned.
4. The borrower will agree to all repair or replacement costs if they are deemed necessary.
5. Rental price _____.
6. Estimated cost of item _____.

Date_____ Education Representative_____

Descriptive Name:	Educational Services Department Hard-Software Rental
Descriptive Type:	Revised
Document Number:	13-12,006
Attachments:	One
Author:	Carol Bradford
Typist:	~~Melissa Arend~~Carol Bradford
Creation Date:	09/25/08
Revision Date:	01~~12~~/17~~22~~/18~~4~~
Prev. Dist. Date:	~~06/23/11~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date:	~~01/29/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Centralized Annual Update Sessions

I. PURPOSE:

Regulatory (DNV, SB 198 – Injury and Illness Prevention Plan IIPP, OSHA) and internal mandates require hospital staff members attend the annual program to update their skills in a variety of areas. The mandatory yearly "update" educates and tests for competency.

II. The Program description is as follows:

A. The update will be scheduled yearly; times vary and will be announced with date publication.

B. Hospital staff members will complete an education/assessment (test) prior to the annual update sessions. The annual update sessions will be conducted in an open house format during a specified timeframe (i.e. one week).

C. On-line education/assessments will be completed by all staff PRIOR to the update, which will include:

1. Quality Improvement
2. Harassment
3. General Safety
4. Medical Equipment
5. Electrical Safety
6. Radiation Safety
7. Hazardous Communication
8. Fire Safety
9. Back Safety
10. Security
11. Disaster
12. Evacuation
13. TB Control Plan
14. Standard Precautions & General Infection Control
15. Advance Directives
16. Patient Rights
17. Ethical Behavior/Compliance
18. Age Specific, Population served and Cultural Diversity
19. HIPAA

D. Additionally online clinical education/assessments will be completed according to position profile prior to the update sessions.

E. Update Sessions:
Staff will be required to complete stations depending on their position profile. The Annual Update sessions will vary, but could consist of the following:

1. Infection Prevention: Reduction of Healthcare Associated Infections (HAI's)
2. Body Mechanics-General/Patient Lifting/Transfer (For patient care related areas) Back ~~Evaluations~~Update
3. CPR BLS Health Care Provider skills and written proctored exam.
4. Clinical Competency Assessment including but not limited to: Blood Glucose Monitoring, Blood Transfusion update, Mock Code Blue/Crash Cart Review and other competencies determined by the Professional Development Team.
5. Pronouncement of Death (optional)

F. CPR-BLS Requirements:

1. The following are required to be renewed in BLS (Health Care Provider) every two years:
Healthcare Provider (includes written testing)

RN	Dietitian
LVN	OR Tech
ED Tech/Tele tech	Home Health Aides
Pharmacist	Medical Assistant
Respiratory Care Practitioner	CNA
Patient and Family Services	
Laboratory (phlebotomist)	Physician (offered)
Physical Therapy	PA (offered)
Medical Imaging	Nurse Practitioner (offered)

III. Policy:

A. This Update is **MANDATORY** for ALL District~~Hospital~~ staff members. Each hospital staff member will attend yearly.

B. The district~~hospital~~ staff member must pass all exams with a score of eighty-four percent (84%) and complete stations as required for the position~~; to at least a competent level per Benner's scoring (2001)~~. If this is not achieved, the ~~hospital~~ staff member will need to repeat a station or the entire update within the time scheduled.

C. Every two years when HCP BLS is due for renewal, the district~~hospital~~ staff member will complete the CPR station. If the CPR station is not passed, the ~~hospital~~ staff member may be asked to attend the 4-hour initial BLS Course.

IV. Implementation:

A. Approximately eight (8) weeks prior to the update, Human Resources and the Educational Services Department will notify department directors of the dates, times, process and distribute appropriate profiles for their district~~hospital~~ staff members.

B. Department directors will guide their ~~hospital~~ staff members to take the appropriate online tests prior to the centralized annual update sessions. Department directors will accommodate district~~hospital~~ staff members to complete the centralized annual update sessions during the specified time frame. Department directors will assure all ~~hospital~~ staff members complete centralized annual update on time.

C. The Educational Services Department will communicate with directors at the end of each day and forward a summary of attendance to Human Resources upon completion of the update. They also note attendance in the Education tracker including CPR completion.

D. Due to the availability for district~~hospital~~ staff members to access Centralized annual update, all ~~hospital~~ staff members should be able to attend and complete the annual update sessions. However, should a small limited amount not attend, Human Resources will communicate~~send a memo to~~ with the Department Director of ~~hospital~~ staff members who did not attend as scheduled. One makeup session may be scheduled. District~~Hospital~~ staff members who do not attend will be subject to disciplinary action. Disciplinary action taken will be noted and documentation of such will be forwarded to the Human Resources Department for their file and noted on the yearly evaluation (reduction of points in mandatory attendance section).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Centralized Annual Update Sessions

Descriptive Type: Revision

Document Number: 13-12,007

Attachments: None

Author: Carol Bradford and Professional Development Team

Typist: Carol Bradford~~/Melissa Arend~~

Creation Date: 11/20/08

Revision Date: 01~~7~~/17~~24~~/18~~5~~

Prev. Dist. Date: ~~03/29/12~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~08/26/15~~	

Effective Date: 08/27/15

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Case Managers, Educational Services, Rural Health Clinics and Home Care

FROM: Administration

SUBJECT: Clinical Services Orientation Policy

PURPOSE: To introduce the new Patient Care employee to the facility and assist them in learning to function safely and effectively in their position.

ORIENTATION: Nursing Employees will be provided a Nursing Orientation by the Education Department and Unit Preceptor. The length of the orientation will depend on the position and the individual (i.e. Traveler and Registry RN's, experienced or new grads). All orientee's will initiate a Competency Assessment Tool during orientation which will be completed during the remainder of their unit orientation and returned to their unit director or designee for review and documentation. The orientee's Competency Assessment Tool will be submitted to Human Resources with the probationary evaluation and kept in the employee Personal file with the exception of the Traveler and Registry RN's which will submit them to Clinical Administration where they will be kept in their Personal file.

(See attached "Clinical Services Orientation Policy Orientation Outline" detailing the following phases)

PHASE I: *For all Nursing Personnel (RN, GRN, LVN, MA, CNA, Unit Secretary, ERT, Tele Tech)*
By the end of this phase the participant will be able to demonstrate compliance with the Department of Nursing Services' policies relating to Organization of the Department, Professional Conduct, and General Unit Operations.

PHASE II: *For all Nursing Personnel (RN, GRN, LVN, MA, CNA, Unit Secretary, ERT, Tele Tech)*
By the end of this phase the participant will be able to demonstrate compliance with the Department of Nursing Services or other department service standards relating to daily operation of the unit.

PHASE III: *For Patient Care Nursing Personnel (*RN, GRN, LVN, MA, CNA, ERT, Tele

Tech)
By the end of this phase the participant will be able to demonstrate compliance with the Clinical Services standards relating to basic patient care nursing skills.

PHASE IV: *For all Licensed Personnel (RN, GRN, LVN, MA) (RT's for Medication Only)*
By the end of this phase the participant will be able to demonstrate knowledge of the Department of Nursing Services policies relating to the functions of their licensure. The extent of this phase depends on the experience and skill level of the participant as identified by the Unit Director and Nursing Education Instructor. All licensed orientees are:

1. Required to complete medication dispensing training prior to medication administration if used in their respective department.
   Required to be monitored by a RN, LVN, MA, or RT (preceptor) or other licensed personnel (mid- level provider) for at least one (1) day while administering medications.

PHASE V: *For all Licensed Personnel (RN, GRN, LVN, GVN, MA)*
This phase will be on the specific unit assigned, with a preceptor (see preceptor policy). The length of this phase will vary depending on position, unit and individual's experience, by the end of this phase they will be able to function independently in their assigned role.

END OF EDUCATION DEPARTMENT ORIENTATION:
An assessment using the "Competency Assessment Tool" (C.A.T.) will take place with the orientee and instructor. A copy of the C.A.T. will be retained in the employee's file in the Education Department. Any areas of concern will be addressed with the preceptor, unit Director and orientee. Documentation will take place at the time.

UNIT ORIENTATION: The original C.A.T. will be sent with the orientee and used with the Unit Specific Competency Assessment Tool, which will be reviewed and completed by the preceptor. A plan for orientation "RN Preceptor Orientation" will be developed with the preceptor and orientee. Any areas of concern will be addressed with the unit Director and orientee; a plan of action will be determined and documented at the time. The completed original CAT will then be reviewed by the unit director and placed in the employee's file in Human Resources or Clinical Administration if Traveler or Registry RN.

Review of the "Competency Assessment Tool" and the Unit Specific Competency Assessment Tool will also be done in conjunction with the probationary evaluation or the End of Assignment evaluation for Traveler RN. A copy of each document will be attached to the evaluation form and retained by Human Resources in the employee's personal file or Clinical Administration if Traveler or Registry RN. Review of the competency assessment tools are done at evaluation even if the employee has not yet completed their tool.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

CLINICAL SERVICES ORIENTATION POLICY
ORIENTATION OUTLINE (Including but not limited to)

PHASE I – MODULE (RN, GRN, LVN, MA, CNA, Unit Secretary, ERT, Tele Tech)

A. Introduction:
   1. Introduction to Clinical Services
   2. Initiate Competency Assessment Tool (C.A.T.)

B. Professional Conduct:
   1. Mandatory Education
      a. CPR
      b. Centralized Annual Update and Clinical Skills Review
   2. Policies, Standards, and Guidelines (actual practice)
   3. Scheduling/Attendance/Calling in sick
   4. Customer Service Standards

C. General Unit Operations:
   1. Quality Review Reports (QRR-Verge)/ Medication Error Reporting/ Fall Reports and Employee Incidents or Exposures
   2. Documentation guidelines
   3. Abbreviations
   4. Military Time
   5. Advance Directives
   6. Interpreting Services
   7. Infection Control/Standard Precautions
   8. Performance Improvement

PHASE II - MODULE (RN, GRN, LVN, MA, CNA, Unit Secretary, ERT, Tele Tech)

1. Assignments/Making/Taking
2. Documentation Tools
   a. Daily Assessments
   b. Plan of Care
   c. Pre-op/Operative Day Record
3. Intake and Output
4. Emergency Procedures
5. Organ and Tissue Donation
6. Age Specific Competencies
7. Module Review

PHASE III (RN, GRN, LVN, MA, CNA, ERT)

1. V/S Competency Check*
2. Oxygen Therapy*
3. Pulse Oximetry*
4. Restraints*
5. Telemetry*
6. Specimen Collection

7. Catheter Care*
8. Infusion Pump
9. Pressure Sore Protocol/Wound Care

PHASE IV: LICENSED PERSONNEL (NEW GRAD ORIENTATION, RN, LVN, MA)

1. Medication Administration*
2. Code Blue*
3. Skills Assessment*
   a. Catheterization* (MA – N/A)
   b. Suture Removal*
   c. N/G Tubes* (MA-N/A)
   d. Blood Glucose Monitor/Care of Diabetic Patient*
   e. PCA (MA-N/A)
   f. Colostomy care* (MA-N/A)
4. Computer Documentation
5. IV Therapy/VADS (MA-N/A)
6. Physician Orders*
7. Pain Management (MA-N/A)
8. IV Moderate Sedation – RN's

PHASE IV MODIFIED: LICENSED (NOT NEW GRAD) (RT for Medication Only)

1. Medication Administration*
2. Skills Assessment
   a. Catheterization*
   b. Suture Removal*
   c. N/G Tubes*
   d. IV Therapy/VADS*
   e. Blood Administration*
   f. Blood Glucose Monitor/Care of Diabetic Patient*
   g. Dressing Change*
   h. Code Blue*
   i. PCA
   j. Colostomy care*
3. Computer Documentation
4. Physician Orders
5. Pain Management
6. IV Moderate Sedation – RN's

***Basic Nursing Competencies if applicable**

Descriptive Name: Clinical Services Orientation Policy

Descriptive Type: Revision

Document Number: 13-12,012

Attachments: None

Author: Carol Bradford

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 11/18/09

Revision Date: 01~~2~~/17~~22~~/18~~4~~

Prev. Dist. Date: ~~03/29/12~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Simulation Lab and In-situ Simulation

I. Purpose:

A. Simulation is a technique, not a technology, the purpose of which is to replace or amplify real patient experiences to evoke critical thinking, coordination and collaboration.

B. The Simulation Lab, (and in-situ simulation) provides the opportunity to learn and practice skills in a simulated health care environment. The lab provides an effective space where participants are able to explore elements of various healthcare fields while learning to provide high quality, safe and comprehensive care for patients and their families.

II. Simulation Location:

A. The lab is located in the OB Department former Delivery Room.

III. Administration / Authority Statement:

A. The Simulation Lab functions under the direction of Educational Services.

B. Confidentiality agreement to be signed yearly, Education to track (see attached).

C. The simulation lab and/or in-situ simulation is used as a learning tool. All scenarios, regardless of their outcome, should be treated in a professional manner, and should never be used to humiliate fellow participants.

D. Due to the unique aspect of simulated clinical experiences, participants are asked to maintain the strictest confidentiality regarding any observations made about the performance of individuals during the simulation experience.

E. As a participant in simulated experiences, whether in the Simulation Lab or in-situ in the clinical environment, participants are expected to keep all events, procedures, and information strictly confidential.

F. All participants are required to review the "Simulation Lab Confidentiality Agreement" and agree to adhere to lab specific guidelines.

IV. Interdepartmental Responsibilities:

A. All facility healthcare providers (including hospital, Contract Services, Home Care and Outpatient Clinics), who use the Simulation Lab, in partnership with Educational Services, are responsible for ensuring the lab is maintained in working order during and prior to leaving the Lab.

V. Procedures:

A. General Lab and In-situ guidelines:

1. To promote successful simulation experiences the following guidelines must be followed:

   a. Maintain confidentiality regarding any observations made about the performance of individuals during the simulation experience.

   b. Maintain confidentiality about the patient/participant information regardless of format: electronic, written, overheard or observed.

   c. Respect all team members and behave in a professional manner.

   d. Report any violations of confidentiality to the facilitator/instructor (i.e.: private photography or recording during testing).

   e. Respect and treat the simulation manikins as if they were live patients.

   f. Report any Latex allergies or sensitivities to the facilitator/instructor.

   g. Ensure Betadine, ink pens, markers, and any printed paper material does not make contact with the manikins.

   h. Follow district hand hygiene practices when touching or

handling the manikin (i.e.: must gel in and gel out and/or wash hands).

i. Ensure the lab is secured (locked) after use.

B. Facilitator/Instructor Access to Simulation Lab & In-situ simulation:

1. Access to the Simulation lab is restricted to facilitators/instructors who have demonstrated competency in the use of Simulation and will be used for no other purpose other than simulation. Sessions should be booked in advance to ensure availability of space and equipment. It is also accessible to staff who require access for administrative purposes. Access to the Simulation Lab is via lock and key. The purposes of this process are to:

   a. Assist Security in knowing who is accessing the lab in the event of an emergency or evacuation.

   b. To protect the safety for all persons who utilize the lab.

   c. To ensure protection for lab supplies and equipment against theft or damage.

   d. Facilitators/instructors who have demonstrated competency in the use of Simulation are the only personnel who are allocated 24 hour/7 day access via lock & key access.

2. Students/staff are not permitted to be left in the lab unsupervised. The scheduled facilitator/instructor must be available throughout the session**.** The scheduled facilitator/instructor must be the last one out of the lab at the end of the day and secure (lock) the lab after use.

3. All facilitators/instructors using the lab are required to ensure the safety and security of the space by ensuring that the lab doors are closed and locked behind them.

4. Students/staff and/or facilitators/instructors are accountable for any damage to models or equipment while utilizing the lab.

5. All users of the lab space are required to ensure that lab is clean and ready for use for the next group.

B. Scheduling Lab and In-situ simulations:

1. Educational Services will schedule usage of the Simulation Lab and availability of a competent simulation facilitator/instructor. A list of competent facilitator/instructors will be maintained with Education.

2. Community Partner bookings will be scheduled through Educational Services based on the availability of the lab and availability of a competent simulation facilitator/instructor.

C. Conduct in the Lab or during In-situ simulations:

1. Follow facility policies and procedure during simulation experiences whether in the Lab or In-situ. This includes, but not limited to:

   a. Infection Control Hand Hygiene #20-8025,

   b. Disposing of Sharps #20-8007

   c. Manikin cleaning #13-12,002

   d. Environment of care #20-8030 low level disinfection

   e. Dress Code ~~#15-2028~~

   f. Use of equipment #22-1006

   g. Code of Conduct #10-1002.1 ~~& 15-2076~~

   h. The use of cell phones #10-1125

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A:

Simulation Lab Confidentiality Agreement

The simulation lab and/or in-situ simulation is used as a learning tool. All scenarios, regardless of their outcome, should be treated in a professional manner, and should never be used to humiliate fellow participants.

Due to the unique aspect of simulated clinical experiences, participants are asked to maintain the strictest confidentiality regarding any observations made about the performance of individuals during the simulation experience.

As a participant in simulated experiences, whether in the Simulation Lab or in-situ in the clinical environment, participants are expected to keep all events, procedures, and information strictly confidential. (This form to be renewed (signed) yearly).

I agree to adhere to the following guidelines:

- Maintain confidentiality regarding any observations made about the performance of individuals during the simulation experience.
- Maintain confidentiality about the patient/participant information regardless of format: electronic, written, overheard or observed.
- Respect all team members and behave in a professional manner.
- Report any violations of confidentiality that I become aware of to the facilitator/instructor (i.e.: private photography or recording during testing).
- Respect and treat the simulation manikins as if they were live patients.
- Report any Latex allergies or sensitivities to the facilitator/instructor.
- Ensure Betadine, ink pens, markers, and any printed paper material does not make contact with the manikins.
- Follow hospital hand hygiene practices when touching or handling the manikin (i.e.: must gel in and gel out and/or wash hands)
- Ensure the lab is secured (locked) after use.

Audiovisual Recording:
Simulated clinical experiences will be recorded to be used during debriefing and for educational purposes only. No future use of the recording will be made without the participant's written permission.

Signature: _____

Printed Name: _____

Employee # _____ Department _____

Date: _____

Location of simulation: ☐ Simulation Lab
☐ In-situ (Please identify location _____)

Descriptive Name: Simulation Lab and In-situ Simulation

Descriptive Type: Revised

Document Number: 13-12,013

Attachments: One

Author: Carol Bradford

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 08/10/10

Revision Date: 01~~2~~/17~~22~~/18~~4~~

Prev. Dist. Date: ~~05/26/11~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/28/15~~	

Effective Date: ~~01/29/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Cafeteria: Rates, Charges, and Discounts

The Cafeteria is maintained for the primary use of employees and staff members. Service to visitors is provided as a courtesy and convenience. Cafeteria hours and meal charges are as follows:

Hours of Service (Subject to change)

Breakfast	7:00 a.m. – 9:00 a.m.
Lunch	11:00 a.m. – 1:00 p.m.
Supper	5:00 p.m. – 8:30 p.m.

Meal Costs and Charges

1. The Cafeteria meal charges are not competitive with outside restaurants and food services. Charges to employees and other hospital staff are set at a minimum necessary to cover the costs of food and labor.

2. All charges are on an a-la-carte basis and are quoted at the full price.

3. Listed prices and discounts may be changed from time to time due to inflation of total costs.

4. ~~Hospital~~ District employees may be ~~are~~ eligible for a ~~forty percent (40%)~~ discount off the list prices, plus sales tax. This applies to food production items only. Beverages, salads, chips and pre-pack items are priced without discounts.

5. ~~The following staff are eligible for discount privileges:~~

   a. ~~Tulare Regional Medical Center Employees~~

   b. ~~Tulare Regional Medical Center Medical Staff~~

   c. ~~Contractual Department Employees~~

   d. ~~Hospital Volunteers~~

e. ~~Others as approved by Administration.~~

6. Family members of employees are welcome to eat in the Cafeteria and will be charged full price.

7. Employees may charge their meals through a payroll deduction upon enrollment and issuance of a valid I.D. number by Human Resources. The employee's name badge and number must be presented for each transaction. The employee is responsible for all charges made to the account number and is responsible to report if their name badge is stolen or missing to Human Resources. The employee is responsible for providing a note to allow pick-up of meals by others when unable to leave their station – Employee Badge must accompany note.

8. Volunteers, Physician, Security meals are charged at the register.

9. All other personnel such as students, contractors, contract employees, must pay cash, credit card, or declining balance card issued by Cherry Street Bistro, but will be afforded the allowable discount~~.~~ if any.

10. Discounts will be given at the time of sale. A receipt will be issued showing the full cost of the purchase, the discount, and the net purchase balance after the discount. Employees are responsible for saving receipts as refunds may not be issued or balances corrected without the receipt.

11. Any questions about amounts deducted or account balances must be submitted prior to the close of the following pay period in question to the Director of Food Service.

Food Service considers the employee charge account and discount as part of the payroll balance. Food Service strives to protect the employee's account and keep an accurate balance. The employee may help by saving receipts. **These records are for the protection of the employee.**

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Cafeteria: Rates, Charges, and Discounts

Descriptive Type: Revised

Document Number: 13-2001

Attachments: None

Author: ~~Melva Hicks/~~ Melva Hicks/ ~~Andrea Carrasco/Ena Menezes~~

Typist: ~~Julie Gresham/Gillian Busch~~Andrea Carrasco/Ena Menezes

Creation Date: 05/19/02

Revision Date: 01/25/18

Prev. Dist. Date: 3/4/03

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~07/18/11~~	
Board of Directors	~~07/27/11~~	

Effective Date: ~~07/28/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Nutrition Services, Clinical Staff and Medical Staff

FROM: Administration

SUBJECT: Screening Adult Patients for Nutritional Risk

POLICY

Hospitalized patients will be screened for nutritional risk within 24 hours of hospital admission.

PROCEDURE

1. All patients are screened for nutrition risk by nursing staff within 24 hours of admission. The nutrition risk screen is a portion of the initial nursing assessment ~~form or rand~~ completed on each hospital in-patient.

2. The nutrition risk screen requests that a referral be made to the registered dietitian if meets one or more indicators are checked. Indicators of nutrition risk include:

   A. Unintentional weight loss
   B. Skin redness or breakdown; Non healing or surgical wounds
   C. Continuous Mechanical Ventilation (CMV)
   D. Difficulty swallowing
   E. Chronic vomiting or Diarrhea greater than 3 days
   F. CVA/Stroke/Altered Mental Status/Confused/Unresponsive
   G. Malnutrition/Failure to Thrive
   H. Multiple Trauma (closed head trauma, penetrating injuries, multiple FX
   I. External or Parenteral Nutrition
   J. Major GI Surgery or Malabsorption Disease.
   K End Stage liver or Renal Disease
   L. Diabetes Mellitus if, newly diagnosed, out of control, DKS, or Gestational

3. The reason(s) for the nutrition risk consult should be stated on the referral sent to the dietitian for the purposes of prioritizing patient care delivery.

4. The nurse completing the nutrition risk screen will document~~should print~~ their name and

date in the electronic medical record~~the form~~. ~~-~~The registered dietitian will ~~sign and date~~ complete the nutrition risk screen ~~on completion of the nutrition assessment~~. ~~-~~ The assessment and all subsequent follow-up evaluations will be in the electronic medical record.
~~filed under the heading "Nutrition Assessment" in the medical record.~~

5. Diet aides responsible for the daily distribution and collection of patient menus are also be in a position to notify the dietitian if problems such as poor appetite, lack of interest in food, unusual food requests or problems with food consistency among others, are noted in our patient populations.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Exhibit A

Adult Nutrition Risk Screen

Must be completed within 24 hours of patient admission

Please check all that apply:

□ Unintentional weight loss. If yes,
how much in the past 1 month: _____In the past 6 months:_____

□ Skin Redness or Breakdown, Non-healing or Surgical Wounds (Please circle)
□ Continuous Mechanical Ventilation (CMV)
□ Difficulty with swallowing. If yes: □ Solids □ Liquids
□ Chronic Vomiting and/or □ Diarrhea ≥ 3 days
□ CVA/Stroke/Altered Mental Status/Confused/Unresponsive (Please circle)
□ Malnutrition/Failure to Thrive
□ Multiple Trauma (closed head injury, penetrating injuries, multiple fx)
□ Enteral or □ Parenteral Nutrition
□ Major GI Surgery or Malabsorption Disorders (Ulcerative colitis, Crohn's)
□ End Stage Liver and/or □ Renal Disease
□ Diabetes Mellitus if: □ newly diagnosed □ out of control □ DKA □ Gestational

If you checked one or more of the above, please order a **Nutrition Consult** as follows:
NUT-Consult Nutrition Risk
Please state the reason (s) for the referral (the indicators checked above)

Person completing the Nutrition Screen (please print name) Date Screen Completed

---

Signature of Registered Dietitian (s) Date of Initial and Follow-up Assessments

Descriptive Name: Screening Adult Patients for Nutritional Risk

Descriptive Type: Revised

Document Number: 13-2008

Attachments: NoneYes

Author: Victoria Carriger/Victoria Carriger Andrea Carrasco/Ena Menezes

Typist: Julie GreshamAndrea Carrasco/Ena Menezes

Creation Date: 01/29/06

Revision Date: 01/31/18

Prev. Dist. Date: 02/23/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	02/06/09	
MEC	02/11/09	
Board of Directors	02/25/09	

Effective Date: 02/26/09

Forward To: Policy Binders (PBX and Administration) and Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Nutrition Services, Clinical Staff and Medical Staff

FROM: Administration

SUBJECT: Screening Pediatric Patients for Nutrition Risk

POLICY

Hospitalized patients will be screened for nutrition risk within 24 hours of hospital admission.

PROCEDURE

1. All pediatric patients will be screened for nutrition risk by nursing staff within 24 hours of hospital admission. The nutrition risk screen is a portion of the initial nursing assessment ~~form or rand~~ completed on each hospital in-patient.

2. The nutrition risk screen requests that a referral be made to the registered dietitian if one or more indicators are checked. Indicators of nutrition risk include:
   - Weight for age equal to or less than 10th percentile or more than the 95th percentile
   - Height for age less than 5th percentile
   - Weight for height less than 5th percentile or greater than 90th percentile
   - Head circumference less than 5th percentile (under 3 years of age)
   - Unintentional weight loss
   - Diagnosis of any of the following:
     □ Diabetes Mellitus
     □ Failure to Thrive
     □ Protein Calorie Malnutrition
     □ Chronic Kidney Disease
     □ HIV/AIDS
     □ Malabsorption Conditions (Crohn's disease, Cystic Fibrosis, Short Bowel Syndrome, Pancreatitis)
   - Iron Deficiency Anemia
   - Developmentally Delayed
   - Multiple or Severe Food Allergies
   - Eating Disorders

Board of Directors: 02/25/09

- Inborn Errors of Metabolism
- Nutrition Support by Feeding Tube or Parenteral Nutrition

3. The reason (s) for the nutrition risk consult should be stated on the referral sent to the dietitian for the purposes of prioritizing patient care delivery.

4. ~~4.~~ The health professional complete~~sing~~ the nutrition risk screen in the electronic medical record and consults with the ~~should print their name and date the form. The~~ registered dietitian. ~~will sign and date the nutrition risk screen on completion of the nutrition assessment.~~ The assessment and all subsequent follow-up evaluations will be in the electronic medical record.

   ~~filed under the heading Nutrition Assessment in the medical chart.~~

5. ~~5.~~ Because the diet aides are responsible for the daily distribution and collection of the patient menus, they will also be in a position to notify the dietitian if problems such as poor appetite, lack of interest in food, unusual food requests or problems with food consistency among others, are noted in our patient population.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Screening Pediatric Patients for Nutritional Risk

Descriptive Type: RevisedNew Policy

Document Number: 13-2009

Attachments: None

Author: Victoria Carriger/Victoria Carriger/Andrea Carrasco/Ena Menezes

Typist: Julie GreshamAndrea Carrasco/Ena Menezes/Carol Bradford

Creation Date: 01/29/09

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Committee Review:	Approval Date:	Comments:
P&T Committee	02/06/09	
MEC	02/11/09	
Board of Directors	02/25/09	

Effective Date: 02/26/09

Forward To Policy Binders (PBX and Administration) Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Emergency Department Patients with Infectious Diseases

POLICY:

When a patient in the Emergency Department (ED) is suspected of having a reportable communicable disease it is the responsibility of the nurse on duty to see that the following occur:

1. In the event the ED Physician identifies a reportable infectious disease in the ED (not by Lab diagnosis) it is reported via the Confidential Morbidity Report (CMR) and faxed to the Health Department (685-4835) or phone (685-5730) A copy of the Confidential Morbidity Report should also be forwarded to the Infection Control Department. (A list of reportable diseases is on the back of the reporting form). Please see Policy #20-8011 Reportable Diseases and Conditions.

2. The final report of all ED diagnostic work and copy of patient charts are given to the ED Physician for their review. All reports are compared to discharge orders to confirm drug/culture match.

3. If follow-up is required, notification of the patient is attempted by telephone. If this is unsuccessful, a certified letter is sent to the address.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~10/01/15~~

APPROVED:

Medical Executive Comm.: ~~09/09/15~~

Board of Directors: ~~09/30/15~~

(13) Ancillary Services
Emergency Services:
Emergency Department Patients With Infectious Diseases
13-3011

State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | *First Name* | *MI*

Home Address: Number, Street | *Apt./Unit No.*

City | *State* | *ZIP Code*

Home Telephone Number | *Cell Telephone Number* | *Work Telephone Number*

Email Address | *Primary Language* ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | *Age* ☐ Years ☐ Months ☐ Days | *Gender* ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | *Est. Delivery Date (mm/dd/yyyy)* | *Country of Birth*

Occupation or Job Title | *Occupational or Exposure Setting (check all that apply):* ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
☐ Filipino ☐ Laotian
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other *(specify)*: _____
☐ White
☐ Other *(specify)*: _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | *Date of First Specimen Collection (mm/dd/yyyy)* | *Date of Diagnosis (mm/dd/yyyy)* | *Date of Death (mm/dd/yyyy)*

Reporting Health Care Provider | *Reporting Health Care Facility*

Address: Number, Street | *Suite/Unit No.*

City | *State* | *ZIP Code*

Telephone Number | *Fax Number*

Submitted by | *Date Submitted (mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | *City* | *State* | *ZIP Code*

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*
_____ _____
_____ _____

☐ ***Untreated***
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
☐ RPR ☐ Pos ☐ Neg ____
☐ VDRL ☐ Pos ☐ Neg ____
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg ____
☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: ____ Upper Limit: ____
AST (SGOT) Result: ____ Upper Limit: ____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 110a (01/18) **(for reporting all conditions except Tuberculosis and conditions reportable to DMV)** Page 1 of 4

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆! = Report immediately by telephone (designated by a ♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a • in regulations.)
✆ = Report by telephone within one working day of identification (designated by a + in regulations).
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

FAX ✆ ✉	Amebiasis
	Anaplasmosis
✆ !	Anthrax, human or animal
FAX ✆ ✉	Babesiosis
✆ !	Botulism (Infant, Foodborne, Wound, Other)
	Brucellosis, animal (except infections due to *Brucella canis*)
✆ !	Brucellosis, human
FAX ✆ ✉	Campylobacteriosis
	Chancroid
FAX ✆ ✉	Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
FAX ✆ ✉	Chikungunya Virus Infection
	Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ !	Cholera
✆ !	Ciguatera Fish Poisoning
	Coccidioidomycosis
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉	Cryptosporidiosis
	Cyclosporiasis
	Cysticercosis or taeniasis
✆ !	Dengue Virus Infection
✆ !	Diphtheria
✆ !	Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
	Ehrlichiosis
FAX ✆ ✉	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	*Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
✆ !	Flavivirus infection of undetermined species
† FAX ✆ ✉	Foodborne Disease
	Giardiasis
	Gonococcal Infections
FAX ✆ ✉	*Haemophilus influenzae*, invasive disease, all serotypes (report an incident of less than five years of age)
FAX ✆ ✉	Hantavirus Infections
✆ !	Hemolytic Uremic Syndrome
FAX ✆ ✉	Hepatitis A, acute infection
	Hepatitis B (specify acute case or chronic)
	Hepatitis C (specify acute case or chronic)
	Hepatitis D (Delta) (specify acute case or chronic)
	Hepatitis E, acute infection
	Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS)
✆	Human Immunodeficiency Virus (HIV), acute infection
	Influenza, deaths in laboratory-confirmed cases for age 0-64 years
✆ !	Influenza, novel strains (human)
	Legionellosis
	Leprosy (Hansen Disease)
	Leptospirosis
FAX ✆ ✉	Listeriosis
	Lyme Disease
FAX ✆ ✉	Malaria
✆ !	Measles (Rubeola)
FAX ✆ ✉	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	Meningococcal Infections
	Mumps
✆ !	Novel Virus Infection with Pandemic Potential
✆ !	Paralytic Shellfish Poisoning
FAX ✆ ✉	Pertussis (Whooping Cough)
✆ !	Plague, human or animal
FAX ✆ ✉	Poliovirus Infection
FAX ✆ ✉	Psittacosis
FAX ✆ ✉	Q Fever
✆ !	Rabies, human or animal
FAX ✆ ✉	Relapsing Fever
	Respiratory Syncytial Virus (only report a death in a patient less than less than five years of age)
	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
	Rocky Mountain Spotted Fever
	Rubella (German Measles)
	Rubella Syndrome, Congenital
FAX ✆ ✉	Salmonellosis (Other than Typhoid Fever)
✆ !	Scombroid Fish Poisoning
✆ !	Shiga toxin (detected in feces)
FAX ✆ ✉	Shigellosis
✆ !	Smallpox (Variola)
FAX ✆ ✉	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉	Syphilis
	Tetanus
FAX ✆ ✉	Trichinosis
FAX ✆ ✉	Tuberculosis
	Tularemia, animal
✆ !	Tularemia, human
FAX ✆ ✉	Typhoid Fever, Cases and Carriers
FAX ✆ ✉	*Vibrio* Infections
✆ !	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉	West Nile Virus (WNV) Infection
✆ !	Yellow Fever
FAX ✆ ✉	Yersiniosis
✆ !	Zika Virus Infection
✆ !	OCCURRENCE of ANY UNUSUAL DISEASE
✆ !	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§ 2500**). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20
Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/tOAHIVRptgSP.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)
Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).
** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org.
CDPH 110a (07/2016)

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Descriptive Name:Emergency Department Patients with Infectious Diseases

Descriptive Type: Revised

Document Number: 13-3011

Attachments: Yes - California Code of Regulations (CCR) §2500 “Reportable Disease and Conditions Report “form (Confidential Morbidity Report on back side)

Author: ~~Joetta Denney~~Josh Warren/Kasey Castro

Typist: Melissa Arend

Creation Date: 03/08/07

Revision Date: ~~05/15/15~~

Prev. Dist. Date: 01/27/11

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	~~06/29/15~~	
MEC	~~09/09/15~~	
Board of Directors	~~09/30/15~~	

Effective Date: ~~10/01/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Nursing Staff, Medical Staff

FROM: Administration

SUBJECT: Newborn Abandonment – (Safe Surrender)

POLICY:

This policy outlines the procedure for accepting physical custody of newborns up to 72 hours old that are voluntarily surrendered by a parent or other person with legal custody. In order to be immune from criminal liability, the parent must surrender the newborn to any designated hospital emergency department employee.

PURPOSE:

Effective **January 1, 2001**~~January 1, 2004~~, The "Safe Surrender" law, Health and Safety Code 1255.7 was revised requiring all hospitals to accept physical custody of newborns up to 72 hours old that are voluntarily surrendered by a parent or other person with legal custody. ~~TDHS~~Tulare Regional Medical Center, as required by this law, has designated ER staff nurses and physicians to receive such newborns, complete documentation and provide medical screening and any necessary care to the newborn. The newborn is eligible for Medi-Cal benefits.

PROCEDURE:

1. Upon surrendering of the newborn, the accepting hospital employee must place two of the Hollister newborn identification (ID) bracelets on the infant and the matching identification bracelet should be given to the person who surrenders the child, this facilitates reclaiming the child at a later date. Any remaining ID bracelets should be attached to the medical records.

2. The ID band number will be documented in the Medical Record.

3. The person surrendering the infant must be given the Child and Family Medical History questionnaire. The questionnaire includes the coded confidential identification matching the newborn. The questionnaire can be filled out at the hospital or mailed in later (provide envelope for mailing).

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4. Upon taking physical custody of the child, an initial medical screening examination and any necessary medical care must be provided by the Emergency Department Physician as mandated by EMTALA. Consent for treatment is not necessary in this case.

5. Notify the Tulare County Child Protective Services (TCPS) at 800-331-1585, no later than 48 hours after taking custody. CPS will assume temporary custody of the newborn upon notification. If custody of the child is not reclaimed within 14 days of surrender, the county agency must file a petition in dependency court.

6. The Emergency department Physician will arrange admission to the nursery or pediatric unit, dependant on the infant's medical condition under the care of the Pediatrician on call; or may be transferred to a tertiary facility for higher level of care as deemed necessary by the emergency department physician.

7. Upon admission, documentation requirement will be the same as all admissions.

8. The infant shall be discharged to Tulare County Child Protective services when medically cleared. In the event the infant is still hospitalized and the parent or legal guardian wishes to reclaim the child, notify Tulare County Child Protective Services (TCPS) and the Nursing Supervisor prior to releasing the infant. The parent or person with legal custody wishing to reclaim the newborn must, show the Identification bracelet given to them at the time of surrendering and it must be compared with the bracelet ID number on the newborn. The parent or legal guardian reclaiming the child must sign the back of the newborn bracelet prior to discharge.

9. The Health Facility Minor Release Report must be completed prior to releasing infant to Child Protective Services, if not reclaimed by the parent or legal guardian.

10. Packets containing the Hollister Newborn ID bracelets, hospital policy, the Child and Family Medical History Questionnaire with return mailing envelope and Minor Release Report will be placed in the Emergency department.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

NEWBORN FAMILY MEDICAL HISTORY QUESTIONNAIRE

Notice: The baby you have brought in today may have serious medical needs in the future that we don't know about today. Some illnesses, including cancer, are best treated when we know about family medical histories. In addition, sometimes relatives are needed for life-saving treatments. To make sure this baby will have a healthy future, your assistance in completing this questionnaire fully is essential. Thank you.

Please answer these questions as well as you can. If you need help answering the questions, please ask. If you would prefer to take this form with you, an envelope is provided for you to mail the completed form to the hospital.

	Circle one
1. When the baby was born, was the mother 35 years of age or older?	No Yes Not Sure

Where the baby's ancestors came from may sometimes give us important information about the baby's health?

2. Is the baby's family:	
a. from Southeast Asia, Taiwan, China or the Philippines?	No Yes Not Sure
b. from Italy, Greece or the Middle East?	No Yes Not Sure
c. African American (Black)?	No Yes Not Sure
d. Latino/Hispanic/Puerto Rican?	No Yes Not Sure
3. Is your family, or your baby's father's family, European (Ashkenazi) Jewish?	No Yes Not Sure

The following questions are about the baby's blood relatives. By "blood relative," we mean the baby's mother, father, sister, brother, grandparent, aunt, uncle, niece, nephew, or cousin.

4. Is any blood relative in the baby's family mentally retarded?	No Yes Not Sure
5. Does the baby have any blood relatives who had an unborn baby or a child who had Down syndrome?	No Yes Not Sure
6. Do any of the baby's blood relatives have any other chromosome problems?	No Yes Not Sure
7. Were any of the baby's blood relatives born with:	
a. a heart defect?	No Yes Not Sure
b. a cleft lip and/or cleft palate?	No Yes Not Sure
c. any other birth defect?	No Yes Not Sure
8. Do any of the baby's blood relatives have:	
a. cystic fibrosis?	No Yes Not Sure
b. muscular dystrophy?	No Yes Not Sure
c. hemophilia or other bleeding disorder?	No Yes Not Sure
d. Huntington's disease?	No Yes Not Sure

9. Do any of the baby's blood relatives have any of the following diseases or health problems?

a. high blood pressure?	No Yes Not Sure
b. diabetes?	No Yes Not Sure
c. cancer?	No Yes Not Sure
d. lung disease or breathing problems?	No Yes Not Sure
e. Heart disease or problems?	No Yes Not Sure
f. nerve or nervous disorders?	No Yes Not Sure
g. schizophrenia?	No Yes Not Sure
h. depression or other mental problems?	No Yes Not Sure
i. glaucoma or other eye problems?	No Yes Not Sure
j. hearing difficulty?	No Yes Not Sure

The following questions are about medical conditions that the baby's *mother may have*.

10. Does she have diabetes?	No Yes Not Sure
11. During this pregnancy, has the mother taken:	
a. medications for seizures? (examples are Dilantin, valproic acid, Depakene, Tegretol, Atretol, Mysoline, Tridione)	No Yes Not Sure
b. lithium for depression? (examples are Eskalith, Lithobid, Lithonate)	No Yes Not Sure
c. pills (accutane, isotretinoin) for acne?	No Yes Not Sure
11. Did she have any other problems or complications during her pregnancy?	No Yes Not Sure

Baby's Identification (Bracelet) Number: _____

Date of Birth: _____ /____/_____

Date Form Completed: ____/____/____

Name (optional): _____

Telephone Number (optional): _____

Patient Label

Descriptive Name: Newborn Abandonment - (Safe Surrender)

Descriptive Type: Revision

Document Number: 13-3026

Attachments: One

Author: Lionel Machado/Linda Callanan/Carrie Jones-Angelo

Typist: Melissa Arend

Creation Date: 07/29/04

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Prev. Dist. Date: 06/26/14

Committee Review and Approval:	Approval Date:	Comments:
Emergency Medicine Committee		
OB/GYN		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Nursing Services, Laboratory, Medical Imaging, Pharmacy Services and Medical Records

FROM: Administration

SUBJECT: Investigational Therapies Review

In addition to other functions and purposes, the Pharmacy and Therapeutics (P&T) Committee is established as a Medical Staff Committee to:

1. Review - To review and evaluate any device, procedure, drug, or treatment considered being Investigational and not yet an accepted standard of care proposed for use upon patients in this hospital with the protection of the patient the overriding consideration.

2. Monitor - To assure the proposed plan of use of the device, procedure, drug or treatment is followed in the manner intended or as detailed in the protocol provided by the sponsor.

The Medical Staff P&T Committee functions shall be:

1. To adopt and follow written procedures for conducting its review and monitoring of each study and to report it's findings to the Medical Staff, the sponsor, and the investigator.

2. To continue monitoring the study until the investigation is completed, discontinued, or withdrawn.

PROCEDURE FOR THE APPROVAL OF THE INITIATION OF INVESTIGATIONAL DRUG THERAPY:

1. Any Medical Staff member desiring to initiate Investigational Drug Therapy for a patient admitted to TRMC. should initially contact the sponsoring pharmaceutical manufacturer of the Investigational Drug or the institution responsible for conducting the drug study. The physician may ask for assistance from the Department of Pharmacy Services in establishing these initial contacts.

2. The prescribing physician should obtain from the sponsor a complete Investigational Drug Protocol (IND). If the physician decides after carefully reading the IND that

Investigational Drug Therapy is indicated, he/she should contact the Medical Staff Office and Department of Pharmacy Services. The Director of Pharmacy Services or his pharmacist designee will contact the sponsoring pharmaceutical manufacturer and/or institution for a "Hospital Pharmacy" copy of the IND and other pertinent dispensing information.

3. The prescribing physician must complete FDA Form 1572 (Statement of Investigator) and return the required completed form and attachments to the sponsor.

4. Upon acknowledgment from the sponsor that the physician is accepted as a clinical investigator and receipt of the IND, the prescribing physician shall contact the Medical Staff Office to arrange a meeting of the P&T Committee for presentation of the IND.

5. At the P&T Committee meeting, the prescribing physician will be invited to present the prospective patient's clinical history, IND protocol, and additional relevant information pertaining to the case. An Institutional Review Board (IRB) review of the IND at national level should have been previously completed and documented as satisfactorily meeting the regulator requirements for protection of human subjects.

6. The Committee members shall have access to all components of the Investigational Drug protocol including: The Informed Consent Form, Patient Enrollment Form, Adverse Experience Form, Patient Outcome Form, and Investigator's Brochure prior to making a determination to endorse the therapy.

7. The P&T Committee will review and monitor the Investigational Drug Therapy until it is completed, discontinued or the drug is released for general use by the FDA. The prescribing physician will be invited by the Committee to provide case follow-up and interim reports at a mutually agreed time to verify that therapy is conforming to the investigational study and requirements applicable to the investigation are being fulfilled.

8. The P&T Committee may choose to withhold endorsement of initiation of Investigational Drug Therapy if the Committee feels there is insufficient or incomplete information to reach a positive decision. The prescribing physician will be promptly notified of the P&T Committee's response.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Investigational Therapy Review

Descriptive Type: Revised

Document Number: 13-5002.1

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Manager

Typist: Julie Gresham

Creation Date: 02/04/09

Prev. Dist. Date: 02/23/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Pharmacy

FROM: Administration

SUBJECT: Warming Recommendations for IV Contrast Media, Intravenous (IV) and Irrigation Solutions

I. POLICY

It is the policy of Tulare Regional Medical Center that when Intravenous Contrast Media, intravenous (IV) and Irrigation solutions are stored in any warming device in patient care areas (including Operating Room, Emergency Department, Nursing Units, etc.) they shall be stored according to the manufacturer's recommendations.

II. PROCEDURE FOR IV AND IRRIGATION SOLUTIONS:

1. IV solutions of volumes 150mL or greater can be warmed in their plastic overpouches to temperature not exceeding 40˚ C (104˚), and for a period no longer than 14 days. The expiration date is based on stability data generated from product samples stored at a constant 77˚F. While stored under labeled conditions the product maintains pharmaceutical acceptability. Prolonged storage at higher temperatures may accelerate changes in the stability of the final product.

2. It is not recommended to warm or thaw solutions with microwave radiation. Water baths should never be used for warming solutions in flexible containers due to the increased possibility of fluid transmission and subsequent contamination. It is recommended that controlled temperature warming cabinets are used for the purpose of warming parenteral and irrigation solutions. Solutions should remain in their overwraps until use and should not come into direct contact with any heating elements or hot metal components near the heating elements within the oven.

3. Warming Recommendations for Large Volume Parenteral Solutions:

A. **Once removed from the oven, solution should be used within 24 hours or discarded and not returned to stock supply.** They should not be subsequently returned to the warmer.

4. Warming Recommendations for Flexible Irrigation Solution Containers:

   A. Solutions can be warmed in their overwrap in a dry warming oven at carefully controlled temperatures to temperatures not exceeding:

      1. 40°C (104°F) and for a period no longer than 14 days. **Once removed from the warming cabinet, solutions should be used within 24 hours or discarded and not returned to stock supply. In addition, solution should not be re-warmed.**

5. Warming Recommendations for Irrigation Solutions in Plastic Pour Bottles:

   A. Solutions can be warmed to temperatures not exceeding 50°C (122° F) and for a period no longer than 60 days. **Once removed from the warming cabinet, solutions should be used within 24 hours or discarded and not returned to stock supply. In addition, solution should not be re-warmed.**

6. All Intravenous (IV) and Irrigation solutions **MUST** be dated prior to being placed into the warmer with the expiration date. Solutions must be discarded after the recommended expirations dates if not used.

7. Temperatures must be monitored by staff or temperature alarm system.

IV. PROCEDURE FOR INTRAVENOUS CONTRAST MEDIA WARMING:

CONTRAST MEDIAS ARE NOT TO BE PLACED IN THE WARMER AT ANY TIME.

****NOTE: Any solutions that are warmed at too high of a temperature, damaged, contaminated or have expired must be segregated until they are removed from the hospital.**

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Warming Recommendations for IV Contrast, Intravenous (IV) and Irrigation Solutions
Descriptive Type:	Revised
Document Number:	13-5019
Attachments:	None
Author: Pharmacy Director	~~Debra Austin~~/~~Lee Gardner~~Stefanie Aflague, ~~Interim Director,~~
Typist:	Debra Austin
Creation Date:	01/08/13
Prev. Dist. Date:	09/27/12

Committee Review and Approval:	Approval Date:	Comments:
Pharmacy &Therapeutics Committee	~~02/06/13~~	Virtual Vote Approval
MEC	~~02/13/13~~	
Board of Directors	~~02/27/13~~	

Effective Date:	~~02/28/13~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Pharmacy Hours of Operation

POLICY:

1. As approved by the medical staff committees and Tulare Regional Medical ~~Cneter~~ Center administration, the Pharmacy hours of operation will be seven (7) days per week, ~~6:00~~ 7:00a.m. - ~~9:~~ ~~00~~11:~~00~~7 p.m. Monday through Friday and 7:30a.m. – 6:00p.m. Saturday, Sunday and holidays. After the pharmacy closes, telepharmacy services will be provided by Telnet-Rx. ~~via fax.~~

2. A Pharmacist is on-call 24 hours per day, seven (7) days per week, to assist nursing and/or physician staff in providing optimal patient care.

3. If workload or patient census should necessitate the need for increased or decreased Pharmacy hours of operation, this will be presented to Tulare Regional Medical Center Administration for ~~for~~ consideration.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~11/17/10~~

APPROVED:

Medical Executive Comm.: ~~11/10/10~~

Board Of Directors: ~~11/16/10~~

(13) Ancillary Services
Pharmacy:
Pharmacy Hours of Operation
13-5023

Descriptive Name: Pharmacy Hours of Operation

Descriptive Type: Revised

Document Number: 13-5023

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~ ~~Mimi Clayton, Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: ~~08/10/10~~ 11/04/13

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Pharmacy Safety

POLICY:

1. The Pharmacy Department ~~Director~~ Director is responsible for maintaining safety standards, developing safety rules, supervising and training personnel in departmental standards.

2. The Pharmacy Department ~~Director~~Director is responsible for notifying the Safety Officer in case of any safety hazard.

3. All department employees shall report defective equipment, unsafe conditions, acts or safety hazards to supervisor/manager.

4. Keep electrical cords clear of passageways. Do not use electrical extension cords without written approval of the Engineering Department.

5. All equipment and supplies must be properly stored. Do not store heavy items on top shelves.

6. All personal electric appliances shall be inspected by the Engineering Department for safe use.

7. Scissors, knives, pins, razor blades and other sharp instruments must be safely stored and used. Use of sharp spindles is prohibited.

8. All electric machines with heat producing elements must be turned off when not in use.

9. Smoking is allowed only in designated areas outside of the hospital building.

10. Do not permit rubbish to accumulate.

Effective Date: ~~11/17/10~~

(13) Ancillary Services
Pharmacy:
Pharmacy Safety
13-5026

APPROVED:

Medical Executive Comm.: ~~11/10/10~~

Board Of Directors: ~~11/16/10~~

11. Notify the Engineering Department immediately of improper illumination and ventilation.

12. Furniture and equipment must be arranged to allow passage and access to exits at all times.

13. Minor spills, i.e., water, will be cleaned by the employee who discovers the spill. This will be done immediately. Major spills will be cleaned by Environmental Services.

14. Report faulty equipment to the Engineering Department or vendor as per policy.

15. Obey warning signs.

16. File drawers and cabinet doors shall be closed when not in use. Open only one (1) drawer at a time. Evenly distribute material to prevent the file cabinet from being unbalanced and tipping over.

17. Wear suitable clothing (avoid high heels or jewelry that may catch in machinery).

18. Use appropriate personal protective equipment.

19. Only authorized personnel shall be allowed in the Pharmacy. The door shall be locked when no one is in attendance.

20. Poisons and narcotics shall have a separate and secure storage place.

21. No unidentified substances shall be permitted in the Pharmacy.

22. Container labels shall be checked three (3) times: when the item is removed from the shelf; when actually used; and when it is replaced on the shelf.

23. A bottled liquid shall be poured at such an angle that it does not spill on and obscure the label.

24. Liquids shall be poured below eye level. Splashing shall be avoided. Corrosive chemicals shall be handled with extreme care.

25. Pharmacy staff~~ists~~ shall fill only one (1) prescription at a time to prevent label mix-ups and other errors.

26. Under no circumstances shall contents of partially empty bottles of drugs be combined.

27. ~~Biological r~~Refrigerators shall be equipped with thermometers. T~~he temperature range shall be from 0 degrees to 15 degrees and the~~ Medications~~biologicals~~ shall be stored ~~——~~at proper temperatures.

28. The full name of the patient shall be listed on the prescription label.

29. Drugs stored within the Pharmacy and throughout the hospital are under the supervision of the Pharmacist.

30. Drugs requiring special conditions for storage to ensure stability are properly stored.

31. Distribution and administration of controlled drugs are documented.

32. Emergency drugs are adequate and in proper supply.

33. All drugs shall be labeled adequately including the addition of appropriate accessory or cautionary statements.

34. Discontinued or outdated drugs and containers with worn illegible or missing labels shall be returned to the Pharmacy for proper disposition.

35. Only the Pharmacist or authorized Pharmacy personnel, under the direction and supervision of the Pharmacist, shall dispense medications, make labeling changes or transfer medications to different containers.

36. After Pharmacy hours, drugs needed may be removed i~~n smallest stock container available~~ in the Night Locker by the designated Nursing Supervisor only. A record of such withdrawals shall be made.

37. Used syringes/needles shall be disposed of in a contaminated syringe/needle box. Boxes will be picked up by Environmental Services.

38. Never pick up broken glass with bare hands. Use a pan and brush. Dispose of fragments in puncture proof containers.

39. Understand and practice good body mechanics.

40. Keep to right when going down corridors. Approach intersections carefully. Be sure traffic on other side is clear when opening swinging doors. Do not push doors pen with equipment. Use push panel or door knob.

41. Do not leave equipment standing in traffic lanes. Return equipment to its proper location when not in use.

42. Do not obstruct fire equipment. Know location of fire fighting equipment and how to use it. Know evacuation routes and what to do in case of fire.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Pharmacy Safety

Descriptive Type: Revised

Document Number: 13-5026

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 08/10/10

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Medication Management Program

I. POLICY:

1. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff, shall implement a Medication Management Assessment and Evaluation Program to provide a system to ensure medication use within the organization is conducted in a safe and optimal manner. The Medication Management Assessment and Evaluation Program requires the routine evaluation of literature for new technologies and best practices that have been demonstrated to enhance safety in other organizations to determine if these practices are conducted successfully within the organization or if they should be implemented to improve the medication management system. The Medication Management Assessment and Evaluation Program will identify risk points (including medication errors and adverse drug reactions) and identify areas to improve patient safety as well as the overall use of medications throughout the organization.

2. For the purposes of this program the definition of medication includes:

   A. Prescription medications

   B. Sample medications

   C. Herbal remedies

   D. Vitamins

   E. Nutraceuticals (substances not controlled by the FDA, not proven beneficial by authoritative sources, however the public commonly utilizes – example: Ingestible Shark Cartilage)

Effective Date: 04/26/12 (13) Ancillary Services
Pharmacy:
Medication Management
Program
13-5027

APPROVED:

Medical Executive Comm.: 04/11/12

Board Of Directors: 04/25/12

F. Over-the-counter drugs

G. Vaccines

H. Diagnostic and contrast agents

I. Radioactive medications

J. Respiratory therapy treatments

K. Parenteral nutrition

L. Blood derivatives

M. Intravenous solutions (plain, with electrolytes and/or other drugs)

N. Any product designated by the FDA as a drug

3. The Pharmacy and Therapeutics Committee will maintain oversight for the Medication Management Assessment and Evaluation Program. The program is based on the principles of performance improvement, with a focus on identification and measurement of processes and activities that are high-volume, high-risk, problem-prone and patient safety related. The program includes data collection and measurement of medication management processes, identification of opportunities or areas for improvements, the testing of incremental improvements and the recommendation of improvements to the organization's leaders. The main goal of improving the performance of medication management processes is to continuously improve patient health outcomes and reduce the occurrence of medication related errors and medication related adverse patient outcomes, including adverse drug reactions. The following essential processes will be conducted to adequately assess and evaluate how medication is managed throughout the institution.

   A. Process Design

   B. Performance Measurement

   C. Performance Assessment

   D. Performance Improvement

4. The Pharmacy Department Director is responsible for reporting medication management processes to the Pharmacy and Therapeutics Committee, whose members in turn are responsible for assessing,

monitoring and evaluating the processes and outcomes of the medication management throughout the institution.

II. PROCEDURE:

A. The Pharmacy and Therapeutics Committee will collaborate and work together as a team with the Pharmacy Department Director, and other designated members of the institution, to develop, implement and evaluate the organization wide Medication Management Assessment and Evaluation Program. As appropriate to the setting, individuals involved in the system of medication management include licensed independent practitioners, healthcare professionals and staff involved in medication management processes.

B. Assessment and Evaluation Process: The following core medication management processes carried out by the organization is measured, assessed and evaluated:

1. Selection and procurement
2. Storage
3. Ordering and transcribing
4. Preparing and dispensing
5. Administration
6. Monitoring the effects and side effects on patients

C. Over time, data is collected on all of the above processes.

D. The Pharmacy Department provides fundamental functions as well as key oversight responsibilities and activities in the system of medication management. The Pharmacy Department performs the following functions and activities:

1. Selection and procurement of medications
2. Storage of medications
3. Maintenance of adequate medication inventory
4. Oversight of ordering and transcribing processes
5. Preparation of medications

6. Medication dispensing

7. Direct and indirect scheduled medication security and control

8. Drug floor stock distribution

9. Drug utilization monitoring and evaluation

10. Provision of drug information to the organization's staff

11. Patient/family/staff counseling and education

12. Provision of formal and informal in-service to the nursing and other staff licensed to administer medications

13. Provision of IV additive service

14. Clinical dosing of specific medications (i.e., aminoglycosides)

E. The Pharmacy Department will be responsible to monitor the outcomes of activities through investigation, data collection and monitoring of the internal processes conducted within, or by, the Pharmacy and its personnel. External performance improvement activities related to medication management will be monitored by the Pharmacy Department through data collection from a wide variety of sources including, but not limited to, medication error reports (which include real and potential errors), and adverse drug reaction reports,.

F. The Pharmacy Department will collect data systematically for improvement priorities and continuing measurement. The process of data collection activities will be (when appropriate and as often as possible) collaborative and interdisciplinary in nature.

G. To adequately monitor and evaluate the medication management system in place within the institution the Pharmacy Department collects data on the following:

1. Processes and outcomes

2. Medication errors (actual or potential)

3. Adverse drug events/reactions (actual or potential)

4. High-risk, high-volume and problem-prone processes

5. Patients needs, expectations and department specific patient satisfaction questionnaires and/or surveys

6. Infection control activities

7. Patient safety reports

8. Current literature for new technologies and best practices

9. Risk management issues and findings

H. Performance Measures:

1. Administration of medication is of high-risk and therapeutic benefit to the patient. Medication management processes are measured on an ongoing basis. The following are performance measures or categories of measures for which data is collected, aggregated, reviewed and analyzed in an effort to identify risk points and areas to improve patient safety. The list is not exhaustive and may be revised in accordance with data collected, which may indicate the benefit of inclusion or exclusion of a performance measure from the monitoring and evaluation cycle. Measures include, but may not be limited to:

   a. Medication errors - wrong drug, dosage, time, route or rate of administration, wrong patient, omission, duplication or administration without an order, adverse reaction to medication (includes potential errors or “near misses”)

   b. Medication order filled incorrectly

   c. Medication order prepared incorrectly

   d. STAT medication not sent within established time frames

   e. Controlled substance missing and/or incorrect count

   f. Occurrences that have an adverse result on a patient

   g. Equipment breakage/failure that has an adverse result on a patient

   h. Equipment not available

   i. Security incident

j. Expired, recalled or otherwise unusable drug dispensed

k. Formulary management

l. Labeling of drugs

m. Education of patients and family

n. Drug recall measures

o. Surveillance, prevention and control of infection

p. Research investigational drugs

q. Ambulatory Pharmacy Services

r. Management of Human Resources (i.e., licensure requirements and entry level qualifications)

s. Patient outcomes; long and short range continuing education

t. Technical quality control activities

u. Adverse drug reactions

I. Drug Usage Evaluation is an important component of the Medication Management Assessment and Evaluation Program. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff shall implement as a component of the overall Medication Management Assessment and Monitoring Program a Drug Usage Evaluation Program to ensure the safe, appropriate and efficacious use of medications throughout the institution. Drug usage will be monitored in a systematic and continuous manner. The Pharmacy and Therapeutics Committee will determine the specific medications to be evaluated as well as the criteria to be applied. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.

J. The Drug Usage Evaluation Program will present to the Pharmacy and Therapeutics Committee an annual plan (i.e., schedule) by which medications will be assessed in the forthcoming year.

K. Priorities for the selection of medications for evaluation shall be based on one (1) or more of the following factors:

1. The number of patients affected by the medication use (i.e., frequency of medication use)

2. The significance, including degree of risk, to individual patients

3. The degree to which use of the medication is known or suspected to be problem-prone

4. Ability to improve the outcome of a specific disease for which medication is an integral part of the treatment

L. Criteria for evaluation will be developed by the Pharmacy Department, in conjunction with the medical staff, based on objective measures that reflect the appropriate use of the medication as determined by community medical standards, current literature and best practices. The evaluation shall focus on processes that measure:

1. Prescribing or ordering of medications

2. Transcribing of medication orders

3. Product labeling

4. Packaging and Nomenclature

5. Compounding

6. Dispensing

7. Distribution

8. Administration

9. Education

10. Monitoring the medications' effects on patients

11. Use

M. Criteria for evaluation shall be approved by the Pharmacy and Therapeutics Committee prior to an evaluation being performed.

N. The Pharmacy Department, in conjunction with the medical staff, will conduct the evaluations, obtaining quantitative data and present a written report of findings to the Pharmacy and Therapeutics Committee on a

quarterly basis. Reports shall include criteria, findings, causes/conclusions and recommendations.

O. The Pharmacy and Therapeutics Committee will determine actions to be recommended to the medical staff based on an analysis of:

1. Thresholds or control limits exceeded

2. Undesired patterns or trends

3. Opportunities to improve performance or minimize adverse reactions

P. To adequately address the amount of medications that may prove beneficial for drug usage evaluation priorities for ongoing assessment have been developed. These priorities are based upon the following:

1. The number of patients taking a medication

2. The balancing of risk with therapeutic potential

3. Medications known or suspected to be problem-prone

4. Therapeutic effectiveness, (i.e., use of antibiotics to treat pneumonia)

Q. The Pharmacy and Therapeutics Committee shall determine if, and when, a medication evaluation requires discontinuation or needs to be continued as a:

1. Full evaluation

2. Limited evaluation

R. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.

S. The performance assessment process conducted for evaluation of the medication management program, as a whole is systematic, interdisciplinary and interdepartmental. The Pharmacy Department uses a systematic process to assess collected data. Other disciplines will collect data related to medication management processes conducted within their department. The assessment process will include statistical quality control techniques as needed. Data assessment begins with a clear understanding of the medication management processes under

review. The framework for systematic assessment includes the multidisciplinary analysis of data to answer questions about the processes and outcomes that are being monitored throughout the organization. The following issues shall be assessed and evaluated:

1. Current level of performance

2. Stability of current processes

3. Identification of areas that could be improved

4. Identification of improvement priorities

5. Effectiveness of strategies implemented to improve performance

6. Specifications for new or redesigned processes determined and met

T. An interdisciplinary approach will be made to make comparisons of processes and outcomes over time. The data will be compared and reference databases utilized as needed. Priorities for improvement will be assessed. Improvement activities will be implemented based upon assessment conclusions. The Pharmacy Department as well as the Pharmacy and Therapeutics Committee (as appropriate) will collaborate as necessary with other disciplines throughout the organization.

U. The organization will systematically improve the performance of its medication management system. The Pharmacy and Therapeutic Committee will assess and evaluate data provided and will determine and implement strategies to improve performance. The Pharmacy and Therapeutics Committee will implement actions that result in desired, measurable changes in processes. To achieve improvements and improve patient safety, the Pharmacy and Therapeutics Committee will participate in the following performance improvement activities:

1. Planning

2. Testing

3. Assessing results and redesigning if necessary

4. Implementing

5. Assessing the effectiveness of implemented actions

6. Reevaluation as deemed necessary to assure gains made are sustained

V. Practitioner specific outcomes of medication management assessment and evaluation review will be included in the practitioner's quality and competency profile for reappointment purposes. This includes review outcome of Drug Usage Evaluation and other clinically significant issues within the Medication Management Assessment and Evaluation Program as a whole.

III. External References:
External resources as applicable shall be utilized to enhance medication safety program at TRMC.

The list includes (but not limited to):

1. American Society of Health-System Pharmacists (ASHP)
2. AYR audits
3. California Department of Public Health
4. California Board of Pharmacy
5. California Hospital Association
6. Comprehensive Pharmacy Services
7. CMS Conditions of Participation
8. DNV
9. Institute of Health Care Improvement
10. Institute of Safe Medicine Practice (ISMP)
11. Joint Commission Standards

IV. <u>ANNUAL REVIEW:</u>

A. The Medication Management Assessment and Evaluation Program will be assessed and measured annually for its effectiveness and consistency within the improving organization performance framework in place within the facility. If the identified improvements are not realized within a defined time period, the organization will reexamine the process within the function that is being monitored. The findings, conclusions, recommendations and actions will be communicated by the Pharmacy and Therapeutics Committee to the following:

1. Leadership Team

2. Patient Safety Committee

3. Organization Performance Improvement Committee

4. Medical Executive Committee

5. Governing Body

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Medication Management Program

Descriptive Type: Revised Policy

Document Number: 13-5027

Attachments: None

Author: Abby Adesanya, Pharm.D.

Typist: Abby Adesanya

Creation Date: 03/09/12

Previous Dist. Date: 03/26/09

Committee Review and Approval:	Approval Date:	Comments:
Medication Safety Team	03/12/12	
P&T Committee	04/04/12	
MEC	04/11/12	
Board of Directors	04/25/12	

Effective Date: 04/26/12

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE DISTRICT HOSPITAL

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: FDA Approved Drugs for Non-FDA Approved Use

POLICY:

The Pharmacy Department will monitor the appropriate use of medications in the hospital. It is the responsibility of the Pharmacy Department to monitor and notify the medical staff of any questionable use of medications.

PROCEDURE:

1. The Pharmacy Department shall contact the prescribing physician if a medication ordered is written for a non-FDA approved indication.

2. The Pharmacy Department will provide the medication if supporting documentation is valid in determining the medication as safe and effective. ~~The medication shall be provided as ordered until such time that sufficient supporting documentation can be acquired.~~

3. All cases will be reported and reviewed by the Pharmacy and Therapeutics Committee.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: FDA Approved Drugs for Non-FDA Approved Use

Descriptive Type: Revised

Document Number: 13-5032

Attachments: None

Author: ~~Ralph Leoni, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 02/02/09

Prev. Dist. Date: 02/23/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~02/06/09~~	
MEC	~~02/11/09~~	
Board of Directors	~~02/25/09~~	

Effective Date: ~~02/26/09~~

Forward To: Policy Binders – 5 – Post on Intranet site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Intravenous Drug Administration Guidelines

POLICY:

The Pharmacy and Therapeutics Committee will maintain guidelines and reference for the safe administration of intravenous drugs.

PROCEDURE:

1. The Pharmacy and Therapeutics Committee will approve guidelines for administration of intravenous drugs. Information provided in the guidelines include, but are not limited to:

   A. Generic name

   B. Route/technique of administration (i.e., IVP, IVPB, IV)

   C. Monitoring parameters (i.e., who, where)

   D. Special considerations (i.e., restrictions, comments)

2. Drugs included may hold either formulary or non-formulary status.

3. Drugs not included on the list may be administered according to official labeling if determined to be safe and appropriate after discussions with the physician, Pharmacist and appropriate Nursing Supervisor.

4. Standard supplemental references will be made available on all patient care units, pharmacies and selected ancillary units.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

APPROVED:

Medical Executive Comm.: ~~03/11/09~~
Board of Directors: ~~03/25/09~~

Descriptive Name: Intravenous Drug Administration Guidelines

Descriptive Type: Revised Policy

Document Number: 13-5033

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~ Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Obtaining Medications for Emergency Purposes

POLICY:

The Pharmacy Department will have an alternate source of drugs in the event of a shortage or outage of prescribed medication or disaster, emergency, or need.

PROCEDURE:

1. In the event a drug or device is needed for the hospital and it is unavailable or is too late to order the item through usual channels, the Pharmacist on duty or other responsible person as outlined in the policy and procedure manual may obtain the drug/device utilizing the following procedure:

   A. The Pharmacist on duty or the on-call Pharmacist in conjunction with the Nursing Supervisor will assess the need for obtaining a particular medication. Consideration will be given to the availability of therapeutic equivalents currently available.

   B. Should it be determined that no substitution can be made, the Pharmacist on duty or the on-call Pharmacist will coordinate the acquisition process (refer to policy 13-5008 Hospital Drug Formulary if a medication is life threatening and not on formulary) by contacting the following outside sources:

      Name: ~~Tulare's Pharmacy~~Sierra View Medical Center Phone #: ~~684-7979~~ 784-1110 ext 3124

      Name: Adventist Health Medical Center Phone #: 582-9000
      Name: Kaweah Delta Medical Center Phone #: 624-2234

   C. If these sources do not have the needed item(s), it is the Pharmacist's responsibility to do everything within his/her power to obtain the needed item(s) from any other hospital, pharmacy or alternate supplier.

Effective Date: ~~11/17/10~~

APPROVED:

Medical Executive Comm.: ~~11/10/10~~

Board Of Directors: ~~11/16/10~~

(13) Ancillary Services
Pharmacy:
Obtaining Medications for Emergency Purposes
13-5036

D. If any item is unavailable or an undue amount of time would lapse before the item could be administered it is the Pharmacist on duty's or the Nursing Supervisor's (after hours) responsibility to contact the prescriber so that an alternate item may be used and that the prescriber may be informed as to the status of his/her patient's drug therapy.

E. All practitioners licensed by the state and with current DEA certification status to order and prescribe medications will be provided with information and education about this facility's protocols for procurement regarding medication shortages, outages and/or medication needed for emergent need. The licensed independent practitioner will be provided this education to alert him/her as to his/her responsibilities (i.e., prescribing alternatives if necessary) when shortages/outages of medications occur. A copy of the Hospital (Pharmacy Department) Drug Formulary will be available in the medical staff office for physician review.

F. During normal Pharmacy hours a member of the Pharmacy staff may be sent to obtain any needed medication from an outside source or may be delivered by calling an approve delivery service. When the Pharmacy is closed, medication may be picked up by an authorized hospital employee or delivered by calling an approved delivery service.

G. Medication obtained from pharmacies outside the hospital must have the pharmacy's label on the container if it is a repackaged drug. This label must include the name of the medication, strength, amount, lot number and expiration date. Any medication received that does not meet this standard will be returned to the outside pharmacy or destroyed by the Pharmacist in charge.

2. In the event of an emergency situation (disaster) where large amounts of medication or specialty medications may be required, the Pharmacy Department ~~Director~~Director will increase the inventory of essential items on hand to expand hospital operations for at least five (5) days. Preparations include:

A. Assessing the available resources:

1. Estimating emergency medication needs

2. Inventorying all essential items currently in stock

3. Determining where probable shortages may occur and allowing for improvisation and substitution whenever possible.

B. Shortages are offset by increasing current inventories of essential items to the degree possible.

C. Medications are rotated and expiration dates carefully noted.
D. Perishable drug supplies are stored in the Pharmacy.

E. Establishing procedures for obtaining emergency procurement of additional medications and supplies:

1. Make prior agreements with local agencies, hospitals, pharmacies and pharmaceutical suppliers to obtain additional supplies, if needed.

2. Maintain a current list of suppliers in the local community.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	~~Concentrated Electrolyte Solutions~~**Obtaining Medications for Emergency Purposes**
Descriptive Type:	Revised
Document Number:	13-5036
Attachments:	None
Author:	~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director
Typist:	Julie Gresham
Creation Date:	08/10/10
Prev. Dist. Date:	10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date:	~~11/17/10~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Medication Recall

POLICY:

- The Director of Pharmacy is responsible for the medication recall process to include:
  - Ensuring recalled medications are removed from all storage areas within the facility, quarantined and appropriately returned/disposed.
  - Notifying prescribers, other healthcare professionals and patients, as appropriate, of the medication recall.
  - Reporting medication recalls for safety reasons to the Pharmacy and Therapeutics Committee.
- The medication recall process applies to all medications stocked within the facility as well as facility owned clinics.

PROCEDURE:

The Director of Pharmacy ensures that actions subsequent to a recall notice comply with the following procedures:

- **Notification of a Medication Recall**
  - The Pharmacy Department is notified of a medication recall through direct mail, the wholesaler's notification, a written or electronic FDA Safety Alert or recall notification.
  - The person receiving notification relays and confirms notification with Pharmacy Leadership (i.e., Pharmacy Director, Clinical Manager) and any off site clinics or hospitals.
- **Retrieval**

All areas of the hospital are inspected to ensure recalled products are removed from all patient care areas of the facility.

Effective Date: ~~11/20/14~~

(13) Ancillary Services
Pharmacy:
Medication Recall
13-5037

APPROVED:

Medical Executive Comm.: ~~11/05/14~~

Board Of Directors: ~~11/19/14~~

Search areas include but are not limited to:

- Pharmacy Department
- Automation Dispensing Cabinets
- Patient Care / Nursing Units
- Ancillary Department Patient Care Areas (ED, Cath Lab, Labor and Delivery, OR, Anesthesia, Radiology)
- Central Supply or Materials Management
- Medication Refrigerators
- Code Carts, Emergency Boxes
- Night Cart or Locker
- Outpatient Care Areas (Infusion Center, Ambulatory Surgery Center)

The inspection process is based upon, but not limited to:

- Product purchase history
- Pharmacy records of manufacturer and lot number of medications stocked and used throughout the hospital
- Re-packaging / compounding and sterile compounding records
- Dispensing records and medication profiles
- **Product Replacement**
  - Recalled medications are replaced with an unaffected lot number of the same medication or generic equivalent, when available.
  - If an unaffected product is not available to replace the recalled medication, the patient's physician is contacted to determine a therapeutic replacement.
- **Product Quarantine and Final Disposition**
  - Recalled medications are quarantined in a designated area separate from active stock. This area is clearly identified.
  - Recalled medications are boxed and labeled: "Medication Recall - Awaiting Disposition - DO NOT USE" (or similar).
  - Recalled medications are returned in accordance with the manufacturers / recall notice specifications.
- **Communication**
  - Medications recalled for safety reasons are reported to the Pharmacy and Therapeutics Committee.

- When a medication is recalled by the FDA or discontinued by a manufacturer for safety reasons, and the affected product has been identified in the facility; individual practitioners and other healthcare professionals ordering, dispensing and/or administering the recalled product are notified. Notification may include: memorandum distributed by fax or posting in the hospital, letter, newsletter, e-mail or any mechanism that ensures the appropriate individuals are informed.
- When indicated, patients who may have received the medication are identified and informed of the recall or discontinuation.
- The Pharmacy Department staff shall remove all lots of recalled or discontinued drugs if found to be in inventory within 24 hours of receiving the recall/discontinuation notice.
- When a sterile compounded drug is recalled, the prescriber or patient of the recalled drug and the board are notified as soon as possible within 12 hours of the recall notice if both of the following apply:

1. Use of or exposure to the recalled drug may cause serious adverse health consequences or death.

2. The recalled drug was dispensed, or is intended for use, in this state.

3. If the recalled drug was dispensed directly to the patient, the notice shall be made to the patient.

4. If the recalled drug was dispensed directly to the prescriber, the notice shall be made to the prescriber, who shall ensure the patient is notified.

5. If the recalled drug was dispensed directly to a pharmacy, the notice shall be made to the pharmacy, who shall notify the prescriber or patient, as appropriate. If the pharmacy notifies the prescriber, the prescriber shall ensure the patient is notified.

- **Documentation and Record Retention**

<u>Drug Recall Action Document</u>

Action taken is documented on the 'Drug Recall Action Document' **Attachment A** below. Documentation includes:

- Product information
- Areas searched / inspected
- Actions executed
  - No product found, no action required
  - Recall notification communicated as appropriate
  - Product segregated from inventory
  - Note the amount of recalled product on hand
  - Product returned via manufacturer's / recall notice specifications

- Date action completed
- Signature of individual completing the action

Record Retention

A chronological file/record of all recall notices, alerts, communications, and the complete 'Drug Recall Action Document' are maintained in a readily retrievable format for a minimum of 3 years.

REFERENCE AND RELATED DOCUMENTATION

- Joint Commission Standard MM.05.01.17 EP 1-4, EC.02.01.01 EP11
- CMS Conditions of Participation §482.25(b)
- Healthcare Facilities Accreditation Program (HFAP) 25.00.00, 25.01.01, 25.01.05
- DNV National Integrated Accreditation for Healthcare Organizations (NIAHO –DNV) MM.1 SR.5; PE.3 SR.6
- Hospital policy addressing recalls and hazard notices of medical devices under jurisdiction of the pharmacy and other departments

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE
Drug Recall Action Document

Name of Product: _____
Manufacturer: _____
Date: _____
Lot #_____NDC#_____

Recall Action:

- Complete the following actions for the recalled medications.
- Sign and date the form when actions are completed.
- Retain a copy for your records.

Areas searched/inspected

☐ No purchase history of the recalled item
☐ Pharmacy Department and Satellites
☐ Automation Dispensing Cabinets
Specify Units:_____
☐ Nursing Units
Specify Units:_____
☐ Medication Refrigerators
☐ Code Carts and Emergency Boxes
☐ Night Cart or Locker
☐ Ancillary Patient Care Areas
- ☐ ED
- ☐ Cath Lab
- ☐ OR
- ☐ Anesthesia
- ☐ Labor and Delivery
- ☐ Radiology

☐ Outpatient (Infusion Center, Ambulatory Surgery Center)
☐ Clinics / Off Site Hospital Campus (inspected or notified)
☐ Was drug shared/loaned/borrowed by another hospital or pharmacy (Yes) (No)?
If yes, please specify amount and hospital or pharmacy_____
☐ OtherAreas:_____
_____

Action Executed

☐ No product found, no action required
☐ Pharmacy Leadership notified
☐ Hospital notification(s) distributed (attach)
☐ Product segregated from inventory
☐ Note quantity on hand:_____
☐ Product returned or pending return via manufacturer's specifications
☐ Recall Notice attached to this document
☐ Filed

Completed By: _____Date: _____

Descriptive Name: Medication Recall

Descriptive Type: Revised

Document Number: 13-5037

Attachments: None

Author: ~~Mimi Clayton~~Stefanie Aflague, Director of Pharmacy

Typist: Melissa Arend

Creation Date: 08/10/10

Revision Date: 10/14/14

Prev. Dist. Date: 11/17/10

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	10/31/2014	
MEC	11/05/14	
Board of Directors	11/19/14	

Effective Date: 11/20/14

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Unusable and Outdated Drugs

POLICY:

1. All discontinued patient drugs; outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels shall be returned to the Pharmacy Department for proper disposal. These drugs shall be stored in an isolated area in the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs shall remain there until they can be returned to the manufacturer or proper disposal or pick up can be made.

2. Drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act shall be destroyed or shipped to the approved agencies for destruction according to current state and federal laws.

PROCEDURE:

1. All drug storage areas of the hospital will be inspected, including the night medication locker and other patient care unit stock areas if applicable, for outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels. The Pharmacy staff member conducting the inspection will remove all of these types of drugs from the area. A record listing the type and amount of drug removed will be completed as each area is inspected.

    A. Nursing or other staff approved by license to administer medications, noting outdated drugs, contaminated drugs, improperly stored drugs and containers with worn, illegible or missing labels, will contact the Pharmacy Department notifying that department of the drug's existence on his or her unit.

        1. Nursing or other licensed staff will placed the unusable medication in the "To Pharmacy "Out Box" which is retrieved by the Pharmacy staff on routine rounds.

2. Medications from outside the hospital brought in by patients and left in the Pharmacy Department for storage greater than 30 days:

A. Shall be logged for disposal in the "Patient's Own Medication Log".

~~B. Controlled substances brought in by the patient shall be logged for destruction in the presence of two (2) pharmacists. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of witnesses shall be recorded on the "Patient's Own Medication Log".~~

~~C~~B. The records shall be kept for three (3) years.

3. The Pharmacy Department shall review the record of unusable drugs (from within the Pharmacy Department and from patient care units) and match the amount of drugs retrieved as unusable against the Pharmacy's record of inventory for the particular medication.

   A. Controlled substances and scheduled drugs listed in Schedules II, III, IV or V of the Federal Comprehensive Drug Abuse Prevention and Control Act shall be destroyed or shipped to the approved agencies for destruction according to current state and federal laws.

   B. Destruction of a controlled substance will be performed in the presence of two (2) licensed nurses or licensed pharmacy staff, and the disposal will be documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason.

4. Any medications that are identified and returned as unusable ~~or that were brought in by a patient and not claimed within 30 days after discharge~~ shall be either returned to the manufacturer or discarded in designated containers for pick up and destruction by the approved disposal company.

   A. Unusable drugs may be returned to the manufacturer for credit dependent upon the manufacturer's policies and the type of medication itself.

      1. Medications that may be returned to the manufacturer will be returned per the manufacturer's instructions.

      2. Medications that are to be disposed will be sequestered and placed in the approved area of the Pharmacy Department designated for disposal company retrieval or manufacturer return.

5. A record of removal from the facility will be kept with documentation on the unusable drug final disposal record, which includes the name of the disposal company, the

name, strength and quantity of medications for disposal, reason for disposal and the date and time the medications were removed from the Pharmacy Department. The Pharmacy Department will maintain a list of approved disposal companies after review and approval by the Pharmacy and Therapeutics Committee. To receive approval by the Pharmacy and Therapeutics Committee the company must:

A. Supply the Pharmacy Department with an accounting of its medication disposal process to assure proper destruction of medications, and to assure the facility that medications released to the disposal company will not be diverted in any manner.

B. Have adequate quality control processes in place that verify the appropriate disposal processes are conducted successfully.

C. Provide a sample of the company's record keeping documents to assure proper disposal and the prevention of diversion.

6. The "Patient's Own Medication Log" shall be used for documenting the disposal of medications brought in by patients.

7. The Pharmacist will document unusable medications being submitted for credit, unusable, non-returnable drugs submitted for disposal as well as expired or otherwise unusable Schedule II drugs being submitted for disposal.

Questions concerning any aspect of this policy/guideline should be referred to Administration

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Unusable and Outdated Drugs

Descriptive Type: Revised

Document Number: 13-5039

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 08/10/10

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	10/27/10	
MEC	11/10/10	
Board of Directors	11/16/10	

Effective Date: 11/17/10

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Refrigerated Drug Storage

POLICY:

All refrigerated drug storage areas will be inspected daily to ensure compliance with drug storage standards.

DEFINITIONS:

1. Refrigerator temperature range: 2.2º C (36º F) to 7.7º C (46º F)

2. Room temperature range: ~~15~~ 20º C (~~59~~ 68º F) to ~~30~~ 25º C (~~86~~ 77º F) but excursions between 15°C (59º F) and 30°C (86º F) are allowed.

3. Freezer temperature range: -10º C to -25º~~30~~ C

PROCEDURE:

1. Drug storage refrigerators will be inspected daily by the Pharmacy Technician or Designee. A daily record log of temperature readings will be maintained on the outside door of the refrigerator or by a s~~S~~mart-r~~R~~emote m~~M~~anager p~~r~~ovided by ~~Cardinal Health (Pyxis)~~the automated dispensing devices.~~.~~ Those areas which store vaccines will have temperatures monitored – twice daily (roughly every 12 hours).

   A. If temperature varies outside the normal range the Pharmacy Technician will attempt an adjustment of the temperature dial and re-evaluate in two (2) hours.

   B. If unsuccessful the technician or designee will notify the Engineering Department to fix the refrigerator.

   C. In such a case, all drugs will be removed and appropriately stored elsewhere until repairs are completed. The nonfunctioning refrigerator will be clearly marked as needing repair and not to be used.

Effective Date: ~~11/17/10~~

(13) Ancillary Services
Pharmacy:
Refrigerated Drug Storage
13-5040

APPROVED:

Medical Executive Comm.: ~~11/10/10~~

Board Of Directors: ~~11/16/10~~

2. All drugs requiring freezer temperature storage will be stored in the central Pharmacy. The central Pharmacy freezer will be fitted with a continuous monitoring temperature gauge and alarm.

   A. In the event of variance from normal temperature range, the Pharmacist will be consulted immediately to determine the disposition of frozen drugs.

3. Refrigerators in the ICU, Med/Surg 1, Med/Surg 2, Med/Surg 3, PACU, Cath Lab, ACU, OB and ED are fitted with a ~~Pyxis Smart Remote Manager.~~smart remote manager. The ~~S~~smart-~~R~~remote ~~M~~manager will monitor these refrigerators and notify the Pharmacy Department (via ~~Pysis~~ automated dispensing device console) that temperatures remain between 36º-46 degrees. In the event of notification of the Pharmacy Department that temperatures are out of range, the Engineering Department will be called to adjust the temperature gauge and assess the refrigerator.

4. Inspection of drug storage refrigerators on nursing units or non-nursing units (i.e., Imaging, Respiratory Therapy) without ~~Pyxis S~~smart-~~R~~remote ~~M~~manager will be conducted at least daily (twice a day if contains vaccines) and logged according to the above procedure by individuals designated by the area's manager. Some areas may also use other commercially purchased alarm systems. Compliance with this requirement will be monitored by the department manager or his/her designee.

5. Monitoring refrigerator temperatures and ensuring the integrity of medications requiring refrigeration is a joint effort between Nursing, Pharmacy, Engineering and other ancillary departmental designee's.

   A. All personnel who access refrigerated medications are expected to ensure appropriate temperatures when medications are removed. If noted to be out of range, the nurse or designee shall notify the Pharmacy or take action to resolve the issue and ensure mediation integrity if after Pharmacy hours.

   B. Units with ~~S~~smart-~~R~~remote ~~M~~managers will observe for the refrigerator warnings icon whenever ~~Pyxis~~ the automated dispensing device is accessed. If the temperature out of range icon is noted, the pharmacy should be notified. If after Pharmacy hours, the nursing supervisore ~~shall~~ take steps to resolve the issue and/or remove the medications and store appropriately (e.g. in another medication only refrigerator, until the issue can be resolved).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Refrigerated Drug Storage

Descriptive Type: Revised

Document Number: 13-5040

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 08/10/10

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Drug Procurement/Inventory Control

POLICY:

Responsibility for control of medications within Tulare Regional Medical Center rests with the Pharmacy Department. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital. These policies will be approved by the Pharmacy & Therapeutics Committee.

PROCEDURE:

1. Acquisition:

    A. The Pharmacy Department is responsible for the acquisition of pharmaceuticals for TRMC. The Pharmacist is responsible for specification as to quality, quantity and source of supply for all drugs used in the hospital. Special consideration is given to the current ASHP Guidelines for Selecting Pharmaceutical Manufacturers and Suppliers. Only those medications approved by the Pharmacy & Therapeutics Committee for use will be routinely stocked and stored.

        1. Practical decisions about the source of multi-vendor (generic equivalent) drugs are deferred to the purchasing group and the competitive bid structure.

        2. Medications for distribution to patient care units are provided in the most ready-to-administer form available, in prepackaged patient unit doses whenever possible.

        3. All medications and chemicals used to prepare medications are accurately labeled with contents, expiration dates and appropriate warnings.

2. Storage:

APPROVED: Drug Procurement/Inventory Control
Medical Executive Comm.: ~~03/11/09~~
13-5042

Board of Directors: 03/25/09

A. Medications are stored under proper conditions as stated by the medication manufacturer to assure medication stability.

1. Medications are stored in a secure manner.

2. The Pharmacy Department is locked at all times. Access is limited to Pharmacists and Pharmacy Department personnel under the direct supervision of a Pharmacist.

3. ~~Pyxis Medstations~~Automated dispensing machines are used to store unit-of-use medications in the patient medication dose system.

4. Medication rooms on patient care units used for storage of floor stock medications will remain locked. Access is limited to licensed nursing personnel, Respiratory Therapists, and Pharmacy personnel.

5. ~~To reduce the likelihood of dispensing errors, m~~Medications stored in the Pharmacy Department will be stored alphabetically by ~~brand~~generic name~~.~~

6. All high-risk drugs and drugs with a higher potential for dispensing error due to look-alike/sound-alike names, will be stored with a secondary caution label (red alert label), ~~and will be segregated from other medications~~ thereby alerting staff for the necessity of taking additional dispensing precautions.

3. Inspection:

A. All drug storage areas within the hospital will be inspected monthly by the Pharmacy Department. A report of inspection will be maintained by the Pharmacy Department. Reports of discrepancies will be shared with the Clinical Manager of the unit involved.

1. Expired, damaged and/or contaminated medications will be removed from drug storage areas within the hospital during the Pharmacy inspection and will be returned to the Pharmacy Department for proper disposal.

2. Expired, damaged and/or contaminated medications will be stored in an isolated area in the Pharmacy Department that has been designated for

the storage of such unusable drugs. The drugs shall remain there until proper disposal or pick up can be made.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Drug Procurement/Inventory Control

Descriptive Type: Revised

Document Number: 13-5042

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~ Stefanie Aflague, Pharmacy Director~~D~~

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy & Distribution – Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Light Sensitive Medications

POLICY:

Medications that are considered light sensitive, as labeled by their respective manufacturers, will be stored and dispensed in a manner as to protect the medications from light.

PROCEDURE:

1. A list of medications used by this facility that are light sensitive is kept in the Pharmacy Department.

2. Medications that require protection from light will remain in their original manufacturer's container until needed.

3. If a medication comes in a nonlight protected package (i.e., clear ampules, syringe unit-dose package) or removed from the original manufacturer's container, the product will be stored in an amber bag or light resistant bag.

4. If the medication is commercially available in a light resistant package, the medication may be stored on the shelf as it is packaged.

See Attached list of Light Sensitive Medications

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~03/26/09~~

(13) – Ancillary Services
Pharmacy:
Light Sensitive Medications
13-5048

APPROVED:

Medical Executive Comm.: ~~03/11/09~~

Board of Directors: ~~03/25/09~~

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

LIST OF LIGHT SENSITIVE MEDICATIONS ON FORMULARY

~~Acyclovir cap, tab~~
~~Zovirax (Burroughs Wellcome)~~

~~Allopurinol tab~~
~~Zyloprim (Burroughs Wellcome)~~

~~Amiodarone tab~~
~~Cordarone (Wyeth Ayerst)~~

~~Amphotericin B powder for injection~~
~~Fungizone (Apothecon)~~

~~Amyl nitrate inhal~~
~~(Burroughs Wellcome)~~

~~Azathioprine inj, tab~~
~~Imuran (Burroughs Wellcome)~~

~~Betamethasone Sodium Phos/Acetate inj~~
~~Celestone (Schering)~~

~~Bromocriptine Mesylate cap, tab~~
~~Parlodel (Sandoz)~~

~~Calcitrol cap~~
~~Rocaltrol (Roche)~~

~~Carbidopa/Levodopa tab~~
~~Sinemet (Dupont)~~

~~Cefotaxime inj~~
~~Claforan (Hoechst Roussel)~~

~~Ceftazidime inj~~
~~Fortaz (Glaxo)~~

~~Ceftiazone inj~~
~~Rocephin (Roche)~~

~~Cefuroxime Sodium~~
~~Zinacef (Glaxo)~~

~~Ciprofloxacin inj~~
~~Cipro (Miles)~~

~~Cisplatin inj~~
~~Platinol (Bristol Myers~~
~~Fluorouracil inj~~
~~Adrucil (Roche)~~

~~Fluoxymesterone tab~~
~~Halotestin (Upjohn)~~

~~Furosemide inj, tab~~
~~Lasix (Hoechst Roussel)~~

~~Glipizide tab~~
~~Glucotrol (Roerig)~~

~~Haloperidol inj~~
~~Haldol (McNeil)~~

~~Clarithromycin tab~~
~~Biaxin (Abbott)~~

~~Clonidine tab~~
~~Catapres (Boehringer Ingelheim)~~

~~Codeine sol tab, inj~~
~~(Various)~~

~~Cyclosporine inj~~
~~Sandimmune (Sandoz)~~

~~Dantrolene inj~~
~~Dantrium (Proctor & Gamble)~~

~~Deferoxamine Mesylate inj~~
~~Desferal (Ciba)~~

~~Dexamethasone Sodium Phosphate inj~~
~~Decadron (Merck Sharpe & Dohme)~~

~~Digoxin inj, elixir, tab~~
~~Lanoxin (Burroughs Wellcome)~~

~~Diphenhydramine inj~~
~~Benadryl (Parke Davis)~~

~~Doxorubicin HCL inj~~
~~Adriamycin (Adria)~~

~~Doxycycline cap~~
~~Vibramycin (Pfizer)~~

~~Ephedrine inj~~
~~(Various)~~

~~Ergotamine tartrate tab~~
~~Ergostat (Parke Davis)~~

~~Erythromycin cap~~
~~Eryc (Parke Davis)~~

~~Felodipine tab~~
~~Plendil (Merck Sharpe & Dohme)~~

~~Fentanyl citrate inj~~
~~Sublimaze (Janssen)~~

~~Finasteride tab~~
~~Proscar (Merck Sharpe & Dohme)~~

~~Metaproterenol Sulfate inj, inhal soln, syrup, tab~~
~~Alupent (Boehringer Ingelheim)~~

~~Methotrexate inj, tab~~
~~Methotrexate (Lederic)~~

~~Methylergonovine inj, tab~~
~~Methergine (Sandoz)~~

~~Heparin inj~~ ~~(Various)~~	~~Metoclopramide inj~~ ~~Reglan (AH Robins)~~
~~Hydromorphone inj, tab~~ ~~Dilaudid (Knoll)~~	~~Metronidazole inj, tab~~ ~~Flagyl (Searle)~~
~~Isoproterenol inj, inhal~~ ~~Isuprel (Sandofi Winthrop)~~	~~Mivacurium Chloride inj~~ ~~Mivacron (Burroughs Wellcome)~~
~~Isradipine cap~~ ~~Dynacirc (Sandoz)~~	~~Morphine Sulfate inj~~ ~~(Various)~~
~~Itraconazole cap~~ ~~Sporanox (Janssen)~~	~~Nifedipine cap~~ ~~Procardia (Pfizer)~~
~~Ketorolac inj, cap~~ ~~Toradol (Syntex)~~	~~Nimodipine cap~~ ~~Nimotop (Miles)~~
~~Labetalol inj~~ ~~Normodyne (Schering)~~	~~Nitrofurantoin cap~~ ~~Macrodantin (Procter & Gamble)~~
~~Lactulose oral syrup~~ ~~Cephulac (Marion Merrill Dow)~~	~~Nitroglycerin inj~~ ~~Tridil (Dupont)~~
~~Leucovorin calcium inj, tab~~ ~~Wellcovorin (Burroughs Wellcome)~~	~~Nitroprusside inj~~ ~~Nitropress (Abbott)~~
~~Leuprolide Acetate inj~~ ~~Lupron (Tap)~~	~~Norepinephrine Bitartrate inj~~ ~~Levophed (Sandofi Winthrop)~~
~~Levothyroxine tab~~ ~~(Various)~~	~~Ondansetron inj~~ ~~Zofran (Cerenex)~~
~~Lorazepam inj~~ ~~Ativan (Wyeth Ayerst)~~	~~Tetracaine inj, top soln~~ ~~Pontocaine (Sandofi Winthrop)~~
~~Lovastatin tab~~ ~~Mevacor (Merck Sharpe & Dohme)~~	~~Tetracycline tab, cap, syrup~~ ~~Sumycin (Apothecon)~~
~~Pentoxifylline tab~~ ~~Trental (Hoechst Roussel)~~	~~Theophylline cap~~ ~~Slo-Bid (Rhone Poulenc Rorer)~~
~~Phenylephrine inj~~ ~~Neo-Synephrine (Sandofi Winthrop)~~	~~Triamcinolone Acetonide susp for inj~~ ~~Kenalog (Westwood Squibb)~~
~~Phenytoin Sodium inj, cap, oral susp~~ ~~Dilantin (Parke Davis)~~	~~Trimethoprim/sulfamethoxazole tab, oral susp~~ ~~Bactrim (Roche)~~
~~Phytonadione inj~~ ~~Aquamephyton (Merck Sharpe & Dohme)~~	~~Verapamil HCl tab, inj~~ ~~Calan (Searle)~~
~~Potassium Chloride tab~~ ~~Slow-K (Summit)~~	~~Vecuronium inj~~ ~~Norcuron (Organon)~~
~~Pravastatin Sodium tab~~ ~~Pravachol (Squibb)~~	~~Vitamin A inj, cap~~ ~~Aquasol A (Astra)~~
~~Prednisolone Sodium Phosphate~~ ~~Hydeltrasol (Merck Sharpe & Dohme)~~	~~Warfarin Sodium tab~~ ~~Coumadin (Dupont)~~
~~Promethazine HCl inj, tab, oral syrup~~ ~~Phenergan (Wyeth Ayerst)~~	~~Zidovudine cap, syrup~~ ~~Retrovir (Burroughs Wellcome)~~

~~Propofol inj~~ ~~Diprivan (Stuart)~~ ~~Propranolol tab, cap~~ ~~Inderal (Wyeth Ayerst)~~ ~~Rifampin inj~~ ~~Rifadin (Marion Merrill Dow)~~ ~~Secobarbital Sodium inj~~ ~~Seconal (Eli Lilly)~~ ~~Sufentanil Citrate inj~~ ~~Sufenta (Janssen)~~ ~~Sumatriptan inj~~ ~~Imitrex (Glaxo)~~ ~~Tamoxifen Citrate tab~~ ~~Nolvadex (ICI)~~ ~~Terbutaline inj~~ ~~Bricanyl (Marion Merrill Dow)~~	

Medication Name	Dosage Form	Comments
Acyclovir (Zovirax)	Cap, Tab	
Allopurinol (Zyloprim)	Tab	
Alteplase (Activase; Cathflo Activase)	Inj.	Protect from excessive exposure to light during extended storage.
Amino Acid Preparations (Aminosyn)	IV Sol.	Protect from light until time of use.
Aminophylline	Inj.	Protect from light and keep vials in carton until time of use.
Amiodarone (Cordarone; Nexterone)	Tab, Inj	Inj: Protect from light during storage. Avoid exposure to direct sunlight during administration.
Amyl Nitrate	Inh	
Atropine	Tab, Inj	Inj: Protect from light during storage.
Azathioprine (Imuran)	Tab	
Betamethasone Acetate-	Inj.	Protect from light during

Betamethasone Sodium Phosphate (Celestone Soluspan)		storage.
Bromocriptine (Parlodel)	Cap, Tab	
Bumetanide (Bumex)	Inj.	Protect from light during storage.
Bupivacaine-Epinephrine (Marcaine w/Epi; Marcaine w/Epi	Inj.	Protect from light during storage.
Butorphanol (Stadol)	Inj.	Protect from light during storage.
Calcitrol	Cap	
Carbidopa/Levodopa (Sinemet)	Tab	
Cefazolin (Ancef)	Inj.	Protect from light during storage and reconstitution.
Cefepime (Maxipime)	Inj.	Protect from light during storage.
Cefotaxime (Claforan)	Inj.	Protect from excessive light during storage and reconstitution.
Ceftazidime (Fortaz; Tazicef)	Inj.	Protect from light during storage.
Ceftriaxone (Rocephin)	Inj.	Protect from light during storage.
Chlorpromazine (Thorazine)	Inj.	Protect from light during storage.
Ciprofloxacin (Cipro)	Inj.	Protect from light during storage.
Clarithromycin (Biaxin)	Tab	
Clonodine (Klonopin)	Tab	
Cyanocobalamin (Vitamin B-12)	Inj.	Protect from light during storage.
Dantrolene (Dantrium; Revonto)	Inj.	Protect from direct light during storage and use within 6 hours after reconstitution. Protect

		reconstituted solution from direct light.
Dexamethasone Sodium Phosphate (Decadron)	Inj.	Protect from light during storage.
Diazepam (Valium)	Inj.	Protect from light during storage.
Digoxin (Lanoxin)	Elixir, Tab, Inj	Inj: Protect from light during storage.
Diphenhydramine (Benadryl)	Inj.	Protect from light during storage.
Dopamine	Inj.	Protect from light during storage.
Doxycyline (Vibramycin)	Cap, Inj.	Inj: Protect from light during storage, reconstitution, dilution, and administration.
Ephedrine	Inj.	Protect from light during storage.
Epinephrine (Adrenalin)	Inj.	Protect from light during storage.
Epoetin Alfa (Epogen, Procrit)	Inj.	Protect from light during storage.
Eptifibatide (Integrilin)	Inj.	Protect from light until administration.
Esomeprazole (Nexium)	Inj.	Protect from light until time of use.
Factor VIIa Recombinant (NovoSeven RT)	Inj.	Protect from light prior to reconstitution. Keep mixed solution out of direction sunlight.
Felodipine (Plendil)	Tab	
Fentanyl (Sublimaze)	Inj.	Protect from light during storage.
Finasteride (Proscar)	Tab	
Folic Acid	Inj.	Protect from light during storage.
Furosemide (Lasix)	Tab; Inj.	Inj: Protect from light during storage.

Glipizide (Glucotrol)	Tab	
Glucagon (GlucaGen)	Inj.	Protect from light during storage (keep in original package).
Haloperidol Lactate (Haldol)	Inj.	Protect from light during storage.
Human Papillomavirus Vaccine (Gardasill)	Inj.	Protect from light during storage.
Hyaluronic Acid (Hyalgan/Synvisc)	Inj.	Store in the original packaging and protect from light.
Hyaluronidase (Vitrase)	Inj.	Protect from light during storage.
Hydrocortisone Sodium Succinate (Solu-cortef)	Inj.	Protect reconstituted solution from light.
Hydromorphone (Dialudid)	Tab; Inj.	Inj: Protect from light during storage.
Hydroxyzine	Inj.	Protect from light during storage.
Immune Globulin (Gammagard Liquid)	Inj.	Protect from light during storage.
Indigotindisulfonate (Indigo Carmine)	Inj.	Store in the dark, away from direct light, preferably in the original package.
Influenza (inactivated) Vaccine	Inj.	Protect from light during storage.
Insulin Determir (Levemir)	Inj.	Keep unopened product in the carton to protect from light. Do not expose opened or unopened product to direct sunlight.
Insulin Lispro (Humalog)	Inj.	Keep unopened product in the carton to protect from light. Protect opened or unopened product to direct light.
Insulin Lispro/Protamine (Humalog 75/25)	Inj.	Keep unopened product in the carton to protect from light. Protect opened or

		unopened product to direct light.
Insulin Isophane/Regular (Humulin N)	Inj.	Keep opened products away from direct light.
Insulin Regular (Humulin R)	Inj.	Keep opened vials away from light.
Ketamine (Ketalar)	Inj.	Protect from light during storage. May darken upon prolonged exposure to light, but this does not affect concentration.
Ketorolac (Toradol)	Inj.	Protect from light during storage. Prolonged exposure to light may result in discoloration of the solution and precipitation.
Labetalol (Normodyne)	Inj.	Protect from light during storage.
Leucovorin	Inj.	Protect from light during storage.
Leuprolide (Lupron)	Inj.	Protect from light during storage.
Levocarnitiine	Inj.	Protect from light during storage.
Levofloxacin (Levaquin)	Premixed IVPB	Protect from light during storage.
Levothyroxine (Synthroid)	Tab; Inj.	Inj: Protect from light during storage.
Lidocaine (Xylocaine)	Inj	Protect from light during storage.
Lidocaine-Epinephrine (Xylocaine w/Epi)	Inj.	Protect from light during storage.
Linezolid (Zyvox)	Premixed IVPB	Keep infusion bags should kept in the overwrap until ready to use.
Lorazepam (Ativan)	Inj.	Protect from light during storage.
Measles, Mumps, Rubella	Inj.	Protect the vaccine from

Virus Vaccine (MMR II)		light at all times since such exposure may inactive the vaccine viruses. If not used immediately, reconstituted vaccine may be stored for up to 30 minutes if protected from light.
Methotrexate	Tab; Inj.	Inj: Protect from light during storage.
Methylergonovine (Methergine)	Tab; Inj.	Inj: Protect from light during storage.
Methylprednisolone Sodium Succinate (Solu-Medrol)	Inj.	Protect from light during storage.
Metoclopramide (Reglan)	Inj.	Protect from light during storage. Stability of diluted solutions is affected by light exposure; refer to references for more info..
Metoprolol Tartrate (Lopressor)	Inj.	Protect from light during storage.
Metronidazole (Flagyl)	Tab: Premixed IVPB	IVPB: Protect from light during storage.
Mitomycin	Inj.	Protect from light during storage and reconstitution.
Morphine	Inj.	Protect from light during storage.
Naloxone (Narcan)	Inj.	Protect from light during storage.
Neostigmine	Inj.	Protect from light during storage.
Nesiritide	Inj.	Protect from light during storage.
Nicardipine (Cardene)	Inj.	Protect from light during storage. Protect from daylight after dilution.
Nifedipine (Procardia)	Cap	
Nimodipine (Nimotop)	Cap	

Nitrofurantoin Macrocrystal (Macrodantin)	Cap	
Nitroglycerin (Tridil)	Inj.	Protect from light during storage.
Nitroprusside (Nitropress)	Inj.	Protect from light during storage, reconstitution, dilution, and administration.
Norepinephrine (Levophed)	Inj.	Protect from light during storage.
Octreotide (Sandostatin)	Inj.	Protect from light during storage.
Ondansetron (Zofran)	Inj.	Protect from light during storage.
Pantoprazole (Protonix)	Inj.	Protect from light during storage.
Pentoxifylline (Trental)	Tab	
Phenylephrine	Inj.	Protect from light during storage.
Phenytoin (Dilantin)	Cap, Oral Susp	
Phytonadione (Vitamin K)	Inj.	Protect from light at all times.
Poliovirus Vaccine (IPOL)	Inj.	Protect from light during storage.
Polymyxin B	Inj.	Protect from light during storage.
Pravastatin (Pravachol)	Tab	
Prednisolone Sodium Phosphate (Prelone)	Oral Susp	
Prochlorperazine (Compazine)	Inj.	Protect from light during storage.
Promethazine (Phenergan)	Tab, Inj.	Inj: Protect from light during storage.
Propranolol (Inderal)	Tab, Cap, Inj.	Inj: Protect from light during storage.
Otect from light during sto	Inj.	Protect from light during storage.

Rituximab (Rituxan)	Inj.	Protect from direct sunlight during storage.
Sufentanil (Sufenta)	Inj.	Protect from light during storage.
Sumatriptan (Imitrex)	Inj.	Protect from light during storage.
Terbutaline	Inj.	Protect from light during storage.
Tetracaine	Top Soln	
Thiamine	Inj.	Protect from light during storage.
Triamcinolone Acetonide (Kenalog; Triesence)	Intravitreal Inj; Inj.	Protect from light during storage.
Trimethoprim-Sulfamethoxazole (Bactrim)	Oral Susp.	
Tuberculin Skin test (Tubersol; Aplisol)	Inj.	Protect from light during storage.
Varicella Virus Vaccine (Varivax)	Inj.	Protect from light before reconstitution.
Vecuronium (Norcuron)	Inj.	Protect from light during storage.
Verapamil (Calan)	Tab; Inj.	Inj: Protect from light during storage and after dilution.
Warfarin Sodium (Coumadin)	Tab	
Zidovudine (Retrovir)	Cap, Syrup, Inj.	Inj: Protect from light during storage.
Ziprasidone (Geodon)	Inj.	Protect from light during storage and reconstitution.

Descriptive Name: Light Sensitive Medications

Descriptive Type: Revised

Document Number: 13-5048

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~
Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy & Distribution – Administration

Comments:

TULARE DISTRICT HOSPITAL

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Standing Orders

POLICY:

It is the policy of Tulare District Hospital to allow standing orders. Standing orders must meet specified criteria and must be approved by the medical staff. Standing orders are ~~written~~ documents containing medical directives for the provision of patient care in selected stipulated clinical situations. Standing orders are generally developed by the professional members of a healthcare entity.

Standing orders are a group of orders that commonly apply to all or almost all patients of a like category, relating to routine care or standard treatment measures for common problems or conditions.

Standing orders may also address emergency measures, which may be required in life-threatening situations to stabilize a patient's condition or prevent more serious complications, injury or death.

The use of standing orders must be documented as an order in the patient's medical record and electronically signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.

Standing orders are to be considered a starting point in ~~writing~~ orders and should be individualized to the needs of each patient

PROCEDURE:

1. General criteria for standing orders. Standing orders must:

   A. Reflect generally accepted medical practices and therapies.

   B. Be consistent with the legal scope of nursing practice in the State of California in which they will be applied to the patient.

Effective Date: ~~01/15/09~~

(13) Ancillary Services
Pharmacy:
Standing Orders
13-5049

APPROVED:

Medical Executive Comm.: ~~12/10/08~~
Board of Directors: ~~01/14/09~~

C. Be approved for use in this institution through the appropriate medical staff and nursing processes.

D. Be authorized and countersigned by the appropriate physician(s) as soon as possible after the order within 48 hours of their implementation.

E. Be transcribed and verified with the physician prior to being implemented, with the exception of emergency situations.

F. Be individualized as appropriate to the needs and condition of the specific patient to which the order(s) are being applied.

G. Be reviewed by both the medical and nursing staffs on an annual basis and as needed basis for revisions as necessary.

H. Be implemented by a nurse or other licensed healthcare provider whose training and experience qualifies him/her for the duties and responsibilities outlined in the standard orders.

I. Standing orders for medications may be used for specified patients when authorized by a person licensed to prescribe. A copy of standing orders for a specific patient shall be timed, dated and promptly electronically signed by the prescriber and included in the patient's medical record. These standing orders shall:

(1) Specify the circumstances under which the drug is to be administered.

(2) Specify the types of medical conditions of patients for whom the orders may be used.

(3) Be initially approved by the Pharmacy & Therapeutics Committee and be reviewed at least annually by that committee.

(4) Be specific as to the drug, dosage, route and frequency of administration.

2. The patient must be assessed for appropriateness of implementing the standing order.

3. In the event that a change in the order is deemed necessary for the well being of the patient, the ordering physician shall be notified. Orders shall be re-enteredwritten.

REFERENCE:

CMS, Standing Orders in Hospitals - Revisions to S&C Memoranda, October 24, 2008, http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter09-10.pdf

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Standing Orders

Descriptive Type: Revised

Document Number: 13-5049

Attachments: None

Author: ~~Julie Gresham~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 11/08/08

Prev. Dist. Date: 02/23/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~12/3/2008~~	
MEC	~~12/10/08~~	
Board of Directors	~~01/14/09~~	

Effective Date: ~~01/15/09~~

Forward To: Policy Binders – 5 – Post on Intranet site

Disposition: Copy and Distribution – Administration

Comments: Revised per CMS Guidelines 10/28/08 §482.23(c) Preparation and Administration of Drugs

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Automated Dispensing Machines – Removing Medications

POLICY:

Medications will be removed from the automated dispensing machine for only one patient at a time.

PROCEDURE:

1. The nurse will take the patient's eMAR to the automated dispensing machine to identify medications needed.

2. The eMAR is the official record of active medications, not the patient profile on the automated dispensing machine.

3. Depending on the automated dispensing system used, the nurse may be prompted to enter the quantity removed or the system will prompt the nurse to remove the appropriate quantity.

4. The automated dispensing machine will prompt the nurse to remove the medication from the designated drawer.

5. Always follow the five rights of medication administration. Also, check the expiration date of all medications removed from the automated dispensing machine.

6. If no medications are found in the drawer, verify that you are accessing the correct pocket. If no medications are present, cancel the transaction and immediately notify the Pharmacy Department or if after hours, the Nursing Supervisor.

7. When using multi-dose vials, follow the "Use of Multi-dose Vials" policy and procedure. Draw up the dose prescribed in a syringe and place the vial back in the pocket before closing the drawer.

Effective Date: ~~03/26/09~~

APPROVED:

Medical Executive Comm.: ~~03/11/09~~

(13) Ancillary Services
Pharmacy:
Automated Dispensing Machines – Removing Medications
13-5056

8. Any non-controlled medication removed from the automated dispensing machine that is not administered must be returned to the automated dispensing machine. Use the return option and place the medication in the appropriate medication pocket~~return bin drawer.~~using the scanner. Any oversize returns are to be placed in the ~~white bucket with the blue top located next to the Pyxis Medstation~~ "Return to Pharmacy" bucket. ~~Using the return option will credit the patient's account.~~

9. For removal of controlled substances see "Automated Dispensing Machine - Controlled Substances" policy and procedure.

10. Patient-Specific Medications:

    A. Patient-specific medications such as inhalers, ointments, eye drops, ear drops and non-formulary medications are not stocked in the automated dispensing machine. The Pharmacy Department will dispense these items, labeled with the patient's information, to the patient care unit. These items are then stored in storage bins labeled with the patient's ~~name and~~ room number.

    B. When transferring a patient, send all medications in the patient's designated bin along with any refrigerated medications to the new patient care unit.

    C. Upon discharge, ~~discard any of the above~~place all patient specific medications (whether used or not)~~that have been opened/used.~~in the "Return to Pharmacy" bucket. Any bulk medications not used and unopened will be returned to the Pharmacy Department for credit.

11. Discharge Prescriptions:

    A. DO NOT remove medications from the automated dispensing machine to dispense to patients as discharge medications.

    ~~B. No drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication. The medication must be properly labeled and prepared by the Pharmacist in accordance with state and federal laws for use outside of the hospital.~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Automated Dispensing Machines – Removing Medications

Descriptive Type: Revised

Document Number: 13-5056

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy & Distribution – Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Automated Dispensing Machines – Stock Medication

POLICY:

1. The standard medication inventory for each automated dispensing machine will be determined by the Pharmacy Department.

2. Any suggested changes to the stock inventory shall be made to the Pharmacy Manager.

3. The Pharmacy Department is responsible for stocking and unloading of all medications in the automated dispensing machines. The Pharmacist or a Pharmacy Technician under the supervision of a Pharmacist shall stock the automated dispensing machines.

4. All medications stocked in the automated dispensing machines will be electronically recorded in the automated dispensing machine database.

5. All medications stocked in the automated dispensing machine shall be packaged and labeled in accordance with federal and state regulations.

6. The Pharmacy Department is responsible for tracking medication expiration dates and removing those medications from the machines upon expiration.

7. PAR levels are set by pharmacy depending on medication. Inventory levels will be checked daily via the automated dispensing machine database.

8. If a medication is found to be low after the Pharmacy Department personnel stock the automated dispensing machine, the Pharmacy Department will be notified.

9. Stock inventory will also be modified to accommodate active medication orders of current patients.

Effective Date: 03/26/09

APPROVED:

Medical Executive Comm.: 03/11/09

Board of Directors: 03/25/09

(13) Ancillary Services
Pharmacy:
Automated Dispensing Machines – Stock Medication
13-5057

10. If a medication is ordered for a patient that is not stocked in the automated dispensing machine, the first dose will be sent to the patient care unit for administration or it will be loaded. The Pharmacy Department will decided whether the medication will continue to be sent patient specific or loaded into the Omnicell depending on space available.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Automated Dispensing Machines – Stock Medication

Descriptive Type: Revised

Document Number: 13-5057

Attachments: None

Author: Stefanie Aflague, Pharmacy Manager

Typist: Julie Gresham

Creation Date: 03/04/09

Revised Date: 3/12/18

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~N/A	Date change only
MEC	~~03/11/09~~N/A	Date change only
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and post to Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Controlled Substances Purchase, Storage and Distribution – Pharmacy

POLICY:

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

PROCEDURE:

1. The Pharmacy Department Director is responsible for the proper safeguarding of controlled substances within the Tulare Regional Medical Center.

2. The Pharmacy Department Director is responsible for the purchase, storage, accountability and proper dispensing of controlled substances.

3. All applicable state and federal laws governing the handling of controlled substances are enforced.

4. The Pharmacy Department utilizes a perpetual inventory system for all controlled substances. The Pharmacy Department Director is responsible for assuring the accuracy and completion of the perpetual inventory system.

PROCEDURE:

1. Pharmacy Procurement:

    A. Ordering of controlled substances is performed by the Pharmacy Department Director or his/her designee.

Effective Date: 02/23/12

APPROVED:

Medical Executive Comm.: 02/08/12

Board Of Directors: 02/22/12

(13) Ancillary Services
Pharmacy:
Controlled Substances Purchase, Storage and Distribution – Pharmacy
13-5058

~~B. A list of persons authorized to sign DEA order forms (Form 222) for the purchase of Schedule II controlled substances is attached at the end of this policy.~~

2. Pharmacy Receipt of Controlled Substances:

A. The receipt of all controlled substances is documented in the perpetual inventory system.

B. Upon receipt of controlled drugs, the packaging is opened and the count, condition and identification of the drugs are verified.

C. The Pharmacist shall fill out the retained copy of the DEA Form 222 for all Schedule II drugs, indicating the amount received, dates and signs the form. If ordered using CSOS, pharmacist shall fill out the paper copy. ~~The Pharmacist shall also document the perpetual inventory logbook for receipt of Schedule II controlled substances.~~

D. A carbon copy of the wholesaler's invoice will be attached to the retained copy of the DEA Form 222 and filed.

E. Discrepancies in shipment shall be identified and reported to the Pharmacy Department Director. The entire shipment, including the exterior shipping container, will be segregated in a secure storage area within the Pharmacy Department, pending disposition of investigation.

3. Pharmacy Storage:

A. All Schedule II, III, IV, V medications are stored in the ~~Pyxis~~ CII Safe.

B. Entry into the ~~Pyxis~~ CII Safe shall be restricted to Pharmacy personnel only.

C. Schedule III, IV and V substances are also stored in the ~~Pyxis~~ CII Safe.

D. Keys to the ~~Pyxis~~ CII Safe are kept only by the Director of Pharmacy.

4. Dispensing to Patient Care Units:

~~A. Schedule II, III, IV and V Drugs~~

~~B~~A. All Schedule II, III, IV and V drugs are dispensed to the patient care units as secured ~~Pyxis~~ automated dispensing machines if available. Non-ADM units will require the nurse to sign for the medication and paperwork returned to the Pharmacy Department for reconciliation.

~~C~~B. Replenishment will be carried out by Pharmacy personnel based on par levels established in ~~Pxyis~~the automated dispensing machine.

5. Inventory System:

A. A perpetual inventory system is maintained for all Schedule II, III, IV and V controlled substances.

B. A physical inventory of the CII Safe shall take place monthly.

C. ~~C.~~ An annual inventory of all controlled substances shall be taken by a designated pharmacist and shall be kept on file in the Pharmacy Department pursuant to state and federal laws.

D. An inventory of all C-II medications shall take place quarterly.

6. Suspected Tampering of Controlled Drugs:

A. When a pharmacy personnel discovers an irregularity, i.e., tampering, with the controlled substances in the Pharmacy, they are responsible for immediately notifying the Pharmacy Department Director about the suspected tampering.

B. The Pharmacy Department Director or designated Pharmacist separates the suspected drugs from the other drugs contained in the locker. An incident report shall be generated pending further investigation.

7. Reports:

A. Open discrepancies reports shall be reviewed daily by Director of Pharmacy or designee.

8. Discrepancies of Controlled Substances:

A. The Director of Pharmacy or designee shall be notified immediately of all discrepancies.

B. The Director of Pharmacy and or Pharmacist in Charge shall notify the Chief Executive Officer within 30 days of all unresolved controlled substances discrepancies and or suspected theft of controlled substances.

C. The Director of Pharmacy and or Pharmacist in Charge shall notify The California Board of Pharmacy within 14~~30~~ calendar days if due to theft by licensed employee, or 30 days for any other type of loss upon discovery of missing controlled substances.

D. DEA Form 106 will be completed under the following circumstances:

1. Known or suspected theft of any controlled substances

2. Significant loss of controlled substances

9. The list of individuals authorized to sign DEA Form 222 for the purchase of Schedule II Controlled Substances will be kept in the Pharmacy Department.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Controlled Substances Purchase, Storage and Distribution – Pharmacy

Descriptive Type: Revised

Document Number: 13-5058

Attachments: None

Author: ~~Abby Adesanya, Pharm.D.,~~Stefanie Aflague, Director of Pharmacy

Typist: ~~Abby Adesanya, Pharm.D. / Gillian Busch~~Stefanie Aflague

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MEC	02/08/12	
Board of Directors	02/22/12	

Effective Date: 02/23/12

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Unit Dose Distribution System

I. POLICY:

A. The unit dose system of drug distribution is the primary drug delivery system for Tulare Regional Medical Center. It is designed to:

1. Promote the safe and effective administration of drug therapy at a reasonable cost.

2. Detect and prevent errors.

3. Promote effective utilization of personnel.

4. Minimize drug deterioration, obsolescence, pilferage and reduce hospital inventory.

5. Reduce and simplify medication record keeping requirements.

6. Provide greater drug control and accuracy in medication administration and record keeping.

B. All medications supplied for patient use will be issued to the ~~Pyxis Medstation.~~ automated dispensing machines (exception: medications in patient specific bins for IVs/less frequently used medications/bulk medications).

C. Fully profiled ~~Pyxis Medstations~~automated dispensing machines are located on:

1. Med/surg 1
2. Med/surg 2
3. Med/surg 3
4. Intensive Care Unit
5. Obstetrics
6. ~~Southwing~~ACU
7. PACU

D. Non-profiled ~~Pyxis~~ automated dispensing machines~~Medstations~~ are located on:

Effective Date: ~~04/23/09~~

APPROVED:

Medical Executive Comm.: ~~04/08/09~~

Board of Directors: ~~04/22/09~~

(13) Ancillary Services
Pharmacy:
Unit Dose Distribution System
13-5062

1. ~~Acute Care Unit~~Cath Lab
2. Emergency Department (partially profiled)
3. Fast-track (partially profiled)
4. Clinics

~~Pyxis~~ Anesthesia Systems are located on:

1. Operating Room 1
2. Operating Room 2
3. Operating Room 3
4. ~~Cardiac Cath Lab~~

E. ~~Pyxis~~ CII Safe is located in the main Pharmacy Department.

F. Oral liquids that are unavailable in unit doses may be repackaged in appropriate sized containers if not commercially available in smaller quantities.

II. PROCEDURE:

A. The Pharmacist or, ~~Pharmacy~~ Technicians make rounds to all patient care units to retrieve ~~physician orders,~~ discontinued medications and other pharmacy related items. ~~To expedite this process, all floors are encouraged to fax all orders to the Pharmacy Department at the time they are written.~~

B. ~~The orders are brought to the Pharmacy Department.~~ All STAT and NOW orders are processed immediately (within 15 minutes) and delivered to the appropriate patient care units as soon as possible if not already stocked in the automated dispensing machine. The nursing personnel are encouraged to ~~have all STAT and NOW orders hand carried to~~call the Pharmacy Department for immediate service.

C. A profile is created in the hospital computer for each patient admitted to the hospital via the Admitting Department. ~~Upon receipt of the patient admitting sheet, the~~ The nurse~~Pharmacist~~ enters the patient's allergy history into the profile. Other information entered upon admission and by the patient care unit includes: patient name, patient account number, room number, date of birth, age, gender, attending physician, diagnosis,

comorbidities, concurrently occurring conditions, current medications, relevant laboratory values, allergies and past sensitivities, pregnancy and lactation status, height and weight.

D. All medications ordered for each patient are entered into the patient's computerized profile by the Physician ~~Pharmacist~~ or entered by the ~~Pharmacy Technician~~nurse via telephone order and verified~~checked~~ by the Pharmacist. Specific data entry information is contained in the hospital mainframe computer reference manuals.

E. With each order ~~entry~~verification, the Pharmacist reviews the patient's entire medication profile for incompatibilities, potential hypersensitivity reactions, duplications in therapy or other potential risks. ~~When available, the Pharmacist will review and initial the copy of each medication order prior to dispensing.~~ Orders ~~filled~~ entered after normal business hours will be reviewed and processed by an after-hours telepharmacy.

F. The Pharmacist is responsible for clarifying any orders in which there are questions as the appropriateness of drug therapy, dose, route, etc. Should any discrepancies be discovered, the Pharmacist shall contact the physician or the nurse to resolve them prior to dispensing. If necessary, a ~~Pharmacy Communications Form or a Clinical Intervention Log Sheet shall be completed.~~a note or intervention shall be entered on patient's profile.

G. Only a licensed Pharmacist or authorized Pharmacy Department personnel under the direct supervision of a licensed Pharmacist shall dispense medications, make labeling changes or transfer medications to different containers.

H. Daily supplies of routine medications will be accessed via the ~~Pyxis Medstation.~~automated dispensing machine.

I. Medications for patients having an operative procedure are discontinued on the day the patient is scheduled for the procedure. Medication orders must be ~~written following~~re-ordered following the procedure.

J. Medications for patients transferred into or out of the critical care/special care unit shall be discontinued until a new order is ~~written~~entered.

K. All reusable medication returned to the Pharmacy Department is to be returned to stock.

L. Medications in the unit dose area are replenished daily by ordering required medications through the Pharmacy purchasing system.

M. Electronic Medication administration records (MAR) for hospital inpatients are generated ~~by~~ on the hospital mainframe computer system. ~~on a daily basis.~~

N. Fill and exchange procedure:

1. ~~1.~~ Reports are run at least twice daily to refill needed medications to the individual ~~Pyxis Medstations~~automated dispensing machines. As stock-outs and medications not typically loaded occur during the day, the Pharmacy Department will fill adequate supplies to the Medstations as soon as possible.

O. Medications delivered to the individual Medstations will be reviewed and approved by a Pharmacist prior to delivery.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Unit Dose Distribution System

Descriptive Type: Revised

Document Number: 13-5062

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Manager

Typist: Julie Gresham

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P&T Committee	~~04/01/09~~	
MEC	~~04/08/09~~	
Board of Directors	~~04/22/09~~	

Effective Date: ~~04/23/09~~

Forward To: Policy Binders = 5 and post to Intranet site

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTHECARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Titrating and Tapering Medications

POLICY:

It is the policy of Tulare Regional Medical Center to allow orders for titration and tapering of medications. Titration is the progressive increase or decrease of the medication dose in response to the patient's clinical status. Tapering is the progressive reduction in dose or frequency of a medication to achieve a desired status of the patient.

PROCEDURE FOR TITRATION:

1 Orders for medications that require titration must state the prescriber's desires for the patient (i.e., titrate medication to achieve B/P of ___/___). Useful dosage adjustment increments must be known before titrating medication to allow clinical staff to determine how much to increase or decrease the medication as attempts are made to achieve the "ordered state" for the patient. Titration increments may vary depending on the patient's clinical status, comorbid conditions and other factors. The frequency of dose adjustments will vary with upward and downward adjustments generally being unequal. (Upward adjustments depend on how rapid the onset of the drug occurs and the length of time before it peaks, downward adjustments are generally related to the drugs half-life and duration.)

2. Medications ordered for titration must be approved by the Pharmacy and Therapeutics Committee. Safe dose ranges for medications that are to be titrated must be reviewed and approved by that committee (See Attachment A below of Critical Care Drip Guidelines). For titrated medications:

   A. A dose limit (maximum and minimum limits) at which the physician must be called for each titrated medication must be set.

   B. Accepting orders for titration of medications without dose limits is **unsafe**. Therefore orders received for titrated medication without dose limits will not be prepared or dispensed. The Pharmacist will contact the prescriber to obtain dose limits.

C. If a titrated medication continues at or above the dose limit, the licensed independent practitioner ordering the titrated medication must be contacted and must approve the current dose at least every 24 hours by ~~writing~~ entering specific orders with a new dose limit at which he/she should be contacted.

D. Dose limits must be clearly documented on all labels of titrated solutions.

E. Dose limits for titrated medications must be included on any preprinted orders, clinical practice guidelines or written protocols for titrated medications.

F. Clinical staff must assess the patient frequently when titrating medications to detect potential problems as early as possible.

PROCEDURE FOR TAPERING:

1. Medications are ordered to be tapered to protect the patient, when abrupt discontinuation of the medication would harm the patient (physiological rebound) or present the patient with unpleasant effects or withdrawal symptoms. By reducing a medication's dosage in increments, these reactions can be avoided. Additionally, medications are ordered for tapering when gradual reduction of a dose will benefit the patient (i.e., tapering Prednisone).

   A. Orders for tapering of medications must include the dosing limits for tapering the medication and the time factors required to achieve the desired clinical state for the patient.

   B. Orders for tapering of medications without reduction dose and frequency limits are not acceptable. Orders received for tapering of medications without dose and frequency reductions will not be prepared or dispensed. The Pharmacist will contact the prescriber to obtain dose and frequency reduction limits.

   C. Tapering requirements must be clearly documented on all labels of medications to be tapered (i.e., Medrol Dose Pack).

   D. Tapering requirements for medications to be tapered must be included on any preprinted orders, clinical practice guidelines and/or written protocols.

Attachment A: CRITICAL CARE DRIP Guidelines

Vasopressor(s) and Inotropes for hypotension and shock:

After initiation, and then during infusion (if no need to adjust drip rate to a higher rate within an 8 hour period) attempt to wean down every 8 hours—to maintain titration parameters.

Drug	Standard Concentration	Rate; increase by	Max Rate	Titration Parameter
DOBUTamine [Dobutrex®]	250mg/250mL D_5W (1 mg/mL)	***Start***: 0.5-1 mcg/kg/min may also initiate at higher doses (eg, 2.5 mcg/kg/minute) depending on severity of decompensation with titration to desired response ***Change rate***: 2.5 mcg/kg/min every 3 minutes—(if needed) until ScVO2≥70% or SV02≥65%, MAP ≥ 65	***Max:*** 40 mcg/kg/min *Rarely any benefit beyond 20mcg/kg/min*	MAP ≥ 65 Call MD if HR>125
DOPamine	800mg/500mL D_5W (1.6 mg/mL)	***Start***: 1-5 mcg/kg/min ***Change rate***: 1-4 mcg/kg/min at 10-30 min intervals	***Max:*** 50 mcg/kg/min *Rarely any benefit beyond 20mcg/kg/min*	MAP of ≥65 and HR<125. Call MD if HR≥125
EPInephrine	5mg/250ml NS (20 mcg/ml)	***Start:*** 0.1-0.5 mcg/kg/min **Change rate:** 0.05- 0.2 mcg/kg/min every 10-15 min to achieve desired blood pressure goal	***Max:*** 3 mcg/kg/min	**Wean:** may wean incrementally every 30 minutes over 12 to 24 hours
NOREPInephrine [Levophed®]	8mg/250mL D_5W (32 mcg/mL)	***Start:*** 8 -12 mcg/min ***Change rate***: Titrate to desired response	***Max:*** 30 mcg/min	MAP≥65 as tolerated with HR<125. Call MD if HR>130
Phenylephrine [Neo-Synephrine®]	40mg/250mL D_5W (160 mcg/mL)	***Start:*** 100-180 mcg/min ***Change rate***: Titrate to effect	***Max***: 300 mcg/min	MAP≥65 as tolerated with HR<125. Call MD if HR>130

Vasopressin [Pitressin®]	20 Units/100mL NS (0.2 unit/mL)	***Start:*** 0.01 units/min—titrate to minimize rate(s) of catecholamines ***Change rate***: If the target blood pressure response is not achieved, titrate up by 0.005 units/min every 10-15 min .	***Max:*** 0.07units/min (Doses >0.03 units per minute may have more cardiovascular side effects and should only be reserved for salvage therapy)	MAP of ≥65 mmHg Call MD if HR>130 **Wean:** After target blood pressure has been maintained for 8 hours without the use of catecholamines, taper by 0.005 units/min every hour as tolerated to maintain target blood pressure.

Vasodilators

1) Titrate to MAP65-85

2) Attempt to wean down every 8 hours—while maintaining titration parameters.

Drug	Standard Concentration	Rate; increase by	Max Rate	Titration Parameter
NitroGLYCERIN	50 mg/250 mL D_5W (200 mcg/mL)	***Start:*** 10 mcg/min ***Change rate*:** by 10 mcg/min every 3-5 minutes until desired effect.	***Max:*** 200 mcg/min (for chest pain) 100 mcg/min (for hypertension)	Titrate to chest pain relief (score 4 or less) and SBP >100 **Wean:** Slowly decrease over 24 hours
NitroPRUSSIDE (Maximum 24 hour infusion-then requires MD reorder) [Nipride®] [Nitropress®]	50mg/250 mL D_5W (200 mcg/mL)	***Start:*** 0.3-0.5 mcg/kg/min ***Change rate***: by 0.5 mcg/kg/min every 5 minutes until desired effect	***Max:*** 10 mcg/kg/min 5 mcg/kg/min if SrCr>1.5mg/dL	Titrate to MAP<85

Antiarrhythmics

Drug	Standard Concentration	Rate; increase by	Max Rate	Titration Parameter
Amiodarone [Cordarone®] **See Physician's Order Set 516**				
Diltiazem				

[Cardizem®]	125 mg/100mL D_5W (1 mg/mL; Cardizem dose is 25 mL)	***Start:*** Bolus 0.25mg/kg IVP x1 over 2 minutes If response is inadequate, may repeat 0.35mg/kg IVPB bolus 15 minutes later. Then IV continuous infusion : Start at 5mg/hr Infusions >24 hours or infusion rates >15 mg/hr are not recommended ***Change rate:*** may be increased in 5mg/hr increments up to 15mg/hr as needed.	***Max:*** 15mg/hr	Titrate to desired HR Monitor BP
Lidocaine (Xylocaine)	2 g/500mL D_5W (4mg/mL)	Start: Bolus 1-1.5 mg/kg IVP May repeat with 0.5-0.75 mg/kg IVP bolus every 5-10 minutes as needed (max cumulative dose : 3mg/kg) Then start continuous infusion at : 1 mg/min (reduce infusion in patients with CHF, shock, or hepatic disease)	***Max:*** 4 mg/min (1.5 mg/min for patients with CHF, shock, or hepatic disease)	Titrate to desired heart rate

Beta Blockers				
Drug	**Standard Concentration**	**Rate; increase by**	**Max Rate**	**Titration Parameter**
Esmolol [Brevibloc®]	2500mg/250mL NS (10mg/mL)	**Start:** Bolus 0.5mg/kg IVP over 1 minute, then 50 mcg/kg/min infusion **Change rate:** by 50mcg/kg/min no more frequently than every 4 minutes	**Max:** 300 mcg/kg/min	Titrate to desired BP/HR
Labetalol [Trandate®]	500mg/250mL D_5W (2mg/mL)	**Start:** Bolus 20mg over 2 min then 2mg/min infusion **Change rate: titrate to response up to 300mg total cumulative dose (discontinue after 2.5**	**Max: 300mg cumulative dose**	Titrate to desired BP

		hours of 2mg/min). **Usual total dose required: 50-200mg**		

Sedation ***ALL PATIENTS on sedation will be assessed Q 4 hrs using RAMSAY SEDATION SCALE*** Monitor: ECG, HR, Resp. Rate, Oximeter, BP, and ETCO2 Follow Vent Protocol for Sedation Vacation.				
Drug	**Standard Concentration**	**Rate; increase by**	**Max Rate**	**Titration Parameter**
Lorazepam [Ativan®]	20 mg/100 mL D_5W (0.2 mg/mL)	***Start:*** 0.5-1 mg/hour **Change rate:** By 0.5-1 mg/hour every hour to desired level of sedation	***Max:*** 10 mg/hr	**Wean:** If >7 day therapy taper by 25% per day.
Midazolam [Versed®]	100 mg/250 mL NS (0.4 mg/mL)	******ICU sedation in intubated/mechanical vent patients ***** ***Start:*** 2 mg/hour **Change Rate:** By 2 mg/hour every hour to desired level of sedation	**Max:** 16 mg/hour	**Wean:** If >7 day therapy taper by 25% per day.
Propofol [Diprivan®] See physician's order set 624	1000mg/100mL emulsion (10mg/mL)	**Start:** 5mcg/kg/min **Change rate:** 5 mcg/kg/min every 5 min until desired RAMSAY score is achieved.	**Max:** 50mcg/kg/min	**Sedation Vacation:** assess need for sedation daily; decrease infusion by 5mcg/kg/min every 5 min until Ramsey score of 2 to 3 is achieved. **WEAN:** Decrease infusion by 5 mcg/kg/min every 5 min until patient is awake, cooperative, and following commands. Discontinue Propofol 15 minutes prior to extubation.
Dexmedetomidine [Precedex®]	400 mcg/100mL NS (4 mcg/mL)	**Loading Infusion:** 1 mcg/kg IVPB over 10 minutes (may be omitted if patient is either being converted from another sedative and patient is adequately sedated or	**Max:** 1.5 mcg/kg/hr	Manufacturer recommends duration of infusion should not exceed 24 hours; however randomized

		there are concerns for hemodynamic compromise) **Maintenance Infusion:** Start: 0.2 mcg/kg/hr **Change rate:** Adjust rate to desired level of sedation; titration no more frequently than every 30 minutes.		clinical trials have demonstrated efficacy and safety comparable to lorazepam and midazolam with longer term infusions up to 5 days. **WEAN:** Titrate infusion rate so patient awakes slowly.

Other Drips

Drug	Standard Concentration	Rate; increase by	Max Rate	Titration Parameter
Fentanyl	1000mcg/100mL NS (10 mcg/mL)	**Start:** 25 mcg/hr	**MAX:** 200 mcg/hr	Titrate to desired effect for pain management.
Octreotide [Sandostatin®]	500mcg/100mL NS (5 mcg/mL)	**Start**: Bolus of 25-100 mcg IVP (usual bolus dose: 50 mcg) Then continuous infusion of 25-50 mcg/hr	**MAX:** 50 mcg/hr	
Vecuronium [Norcuron®]	100mg/250mL NS (0.4mg/mL)	**Start:** Initital bolus dose of 0.08-0.1 mg/kg IVP Then a continuous infusion of 0.8 mcg/kg/min	**MAX:** 1.7 mcg/kg/min	Monitor depth of blockade every 1-2 hours inititally until stable dose, then every 8-12 hours.

RAMSEY Sedation Scale

1	Anxious, agitated, or restless
2	Cooperative, orientated, tranquil
3	Responds to commands only
4	Brisk response to loud auditory or strong physicial stimulus
5	Sluggish response to loud auditory or strong physical stimulus
6	No response

March 2018

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Titrating and Tapering Medications

Descriptive Type: Revised

Document Number: 13-5065

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

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Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Patient's Own Medication Including Herbals and "Natural" Remedies (Usage and Storage)

I. POLICY:

1. Medications brought in by the patient to be utilized during their stay must meet the following conditions:

   A. Drugs have been ordered by a person permitted by law and license to give such an order, and a credentialed licensed independent practitioner holding privileges at this hospital. The order must be entered in the patient's medical record, i.e., the physician's order must indicate that the "patient may use own medications." The medications to be utilized must be individually noted with their corresponding strengths and directions for administration.

   B. The medication container is clearly and properly labeled.

   C. The contents of the containers have been examined, positively identified and the integrity evaluated by the patient's physician and/or the hospital's Pharmacist.

2. A patient may use his/her own medication on the written order of a physician. Patient's own medication may be used for non-formulary medication orders.

3. For the safety of the patient, herbals and "natural" remedies will be considered medications and will require the same procedure as prescribed medications.

II. PROCEDURE FOR PATIENT USE OF OWN MEDICATIONS:

1. Medications used by inpatients are to be dispensed by the hospital pharmacy. To allow the patient to use their own supply of medicine, the

physician must so order on the patient's chart. This order is to include such information as the name of the drug, strength and the frequency of administration. Prior to administering these medications, the containers will be brought to the pharmacy to be examined and positively identified by the pharmacist or, in his absence, the physician. If unidentifiable, the pharmacy will contact the issuing pharmacy or the prescribing physician for a verification of the prescription. These medications must be stored in the patient's unit dose drawer. The medication nurse will be responsible for making the proper notation on the medication record. Medication not stored in properly labeled prescription containers and not identifiable, shall not be permitted to be administered.

2. The patient will not be allowed to self-medicate or keep his/her own medication at the bedside.

III. STORAGE OF PATIENT'S MEDICATION:

1. All other medications which are brought in by the patient will be dealt with in the following manner:

   A. Medications that have been brought in by patients at admission will be sent home with the family. If not, the medications will be stored in the Pharmacy Department in a specified location.

   B. ~~The medications shall be noted on the Home Medication Physician Order Reconciliation form as well as noted that the medications have been sent to the Pharmacy for storage.~~ The medications will be placed in a bag, marked with the patient's information label and sent to the Pharmacy~~. along with a photocopy of the Home Medication Physician Order form.~~ The Pharmacist (or Nursing Supervisor, after normal Pharmacy hours) will place the labeled bag of medications in a designated place in the Pharmacy or in the night locker until the pharmacy opens. The patient's name, date the medications were placed in the pharmacy/night locker and the person signing the medications in will be completed on the Patient's Own Medication log.

   C. If the patient or patient's representative or nurse picks up the medication, he/she must sign the logbook upon return of the medications to the family. If the patient is discharged after normal Pharmacy hours the patient or patient's representative must pick up the medication once the pharmacy re-opens.~~the Nursing Supervisor will obtain the medications from the Pharmacy, verify the patient's name with that on the bag and give the medication to the patient or the patient's family upon discharge. In addition, the Nursing Supervisor will sign out the medications removed from the Pharmacy on the Patient's Own Medication Log, so that verification may be made by the Pharmacist on the next working day.~~

IV. DISTRUCTION OF HOME MEDICATION NOT RETURNED TO PATIENT/FAMILY:

1. Drugs that cannot be returned to the patient, after being held 30 days after discharge, will be disposed of in the following manner:

~~A. Drugs listed in Schedule II shall be inventoried and a request sent to PRSI for transfer request. Schedules III, IV, and V drugs shall be inventoried and sent to PRSI for proper disposition. Records shall be maintained for all controlled substances sent to PRSI for disposal.~~

~~B~~A. Drugs not listed under Schedule II, III, IV or V shall be sent ~~to Pharmaceutical Recovery Services, Inc. (PRSI)~~ for proper disposal (after removing any patient information).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient's Own Medication Including Herbals and "Natural" Remedies (Usage and Storage)

Descriptive Type: Revised

Document Number: 13-5066

Attachments: None

Author/Reviewer: ~~Lee Gardner, PharmD, Interim~~Stefanie Aflague, Pharmacy Director

Typist: ~~Lee Gardner/Gillian Busch~~Stefanie Aflague

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Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Controlled Drug Management on Patient Care Units

I. POLICY:

To ensure adequate control, dispensing and accountability of all controlled substances in conformity with state and federal regulations.

II. SECURITY:

A. All controlled substances located on all nursing units will be stored in ~~Pyxis Medstations.~~automated dispensing machines.

III. ORDERING CONTROLLED SUBSTANCES:

A. All ~~Pyxis Medstations~~automated dispensing machines will have controlled substances replenished daily using the reporting system for drugs at minimum level via ~~Pyxis.~~the machine's database.

IV. ACCOUNTABILITY:

A. All controlled substances in the automated dispensing machines that have been accessed during a shift ~~located in Pyxis Medstations~~ shall be counted ~~every Saturday~~ by a licensed nurse and witnessed by a second licensed nurse. This inventory shall be conducted entirely within the ~~Pyxis Medstation.~~automated dispensing machine.

B. These controlled substances shall be dispensed only to ~~in~~patients within the hospital upon the ~~written~~ order of a prescriber licensed to prescribe controlled substances.

C. Any discrepancy occurring after receipt of the drug(s) is the responsibility of the nursing staff.

V. WASTAGE:

A. In the event of a controlled substance being discarded or wasted (all or part of an issued dose), the nurse must document the waste in the ~~Pyxis~~automated dispensing machine.

~~Medstation~~ and witnessed by a second licensed nurse.

VI. SUSPECTED TAMPERING OF CONTROLLED DRUGS:

A. It shall be the responsibility of each patient care unit to control and maintain the integrity of all controlled drugs and to make a regular inventory of such drugs during the time they are stored on the unit. When any irregularities, such as tampering, are suspected, the Pharmacy Department will be responsible for the evaluation and proper disposition of the drugs in question.

B. Whenever a nurse discovers an irregularity, i.e., tampering, with the controlled substances on the patient care unit, he/she is responsible for immediately notifying the Nursing Supervisor about the suspected tampering.

C. The Nursing Supervisor shall confiscate the suspected drugs and turn them into the Pharmacy Department.

VII. DISCREPANCY:

A. Whenever a discrepancy occurs in the count of a controlled substance or a suspected tampering occurs, the Nursing Supervisor will be notified immediately. Every discrepancy must be documented and reconciled by the end of each shift. .

B. In the event the discrepancy cannot be rectified, the complete facts must be documented on~~line on a medication error report. a Quality Review Report~~. The Nursing Supervisor must ensure that the incident report documents all the facts and the names of all personnel that may have been involved.

VIII. ADMINISTRATION/RECORDING:

A. When the medication is removed from stock, the ~~Pyxis Medstation~~automated dispensing machine will automatically document date, time, patient, room number and nurse administering medication. Any waste shall be documented with 2 licensed nurses via ~~Pyxis.~~the machine.

B. Pharmacy will check the Controlled Substance overrides on a daily basis.

C. Refer to Hospital policy 13-5053 Automated Dispensing Machines – Quality Control for process.

VIIII. ANESTHESIA:

A. Operating Room:

1. All controlled substance dispositions in the Operating Room shall be documented and controlled via ~~Pyxis~~ Anesthesia Stations.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Controlled Drug Management on Patient Care Units

Descriptive Type: Revised

Document Number: 13-5068

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~ Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

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Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and Post Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Nursing Staff, Pharmacy Staff

FROM: Administration

SUBJECT: Disposal of Controlled Substance Patches

POLICY:

It is the policy of Tulare Regional Medical Center that all excess controlled substances shall be destroyed (commonly known as "wasting" of the substance), if not utilized by the patient. Controlled substances contained in topical patches such as Fentanyl fall into this category. All controlled substance topical patches removed from the patient must be destroyed.

PROCEDURE:

- Routine Destruction: Destruction (or wastage) of any controlled substances must be done in the presence of two licensed individuals who are authorized to control and handle these drugs. The destruction of partial doses of controlled drugs must be done and recorded by two nurses.

- Destruction of Controlled Substance Patches: Topical controlled substance patches removed from the patient due to time/date expiration must be properly destroyed and **not** simply discarded in a trash receptacle. Some controlled substance patches, such as Fentanyl, retain some of their potency for days and may be diverted from common trash receptacles.

- Upon removal of the topical controlled substance patch from the patient, the care provider will ~~cut the patch into quarters and~~ carefully discard the patch into the appropriate narcotic waste container.~~a sharps container.~~

- If a controlled substance patch is to be "wasted" due to contamination, or other reasons (i.e., the patch is not used by the patient), the same process is to be followed. ~~(cut the patch into quarters and discard into a sharps container).~~ The documentation process outlined under the routine destruction component of this policy will then be followed, documenting that the medication was not given and was properly destroyed.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: 11/17/10 (13) Ancillary Services
Pharmacy:
Disposal of Controlled Substance Patches
13-5069

APPROVED:

Medical Executive Comm.: 11/10/10

Board Of Directors: 11/16/10

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Disposal of Controlled Substance Patches

Descriptive Type: Revised

Document Number: 13-5069

Attachments: None

Author: ~~Tom Nguyen, Interim~~Stefanie Aflague, Pharmacy Director

Typist: ~~Julie Gresham~~Stefanie Aflague

Creation Date: 08/10/10

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	10/27/10	
MEC	11/10/10	
Board of Directors	11/16/10	

Effective Date: 11/17/10

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments: Changed policy from Clinical Services to Pharmacy Policy
Previous policy #12-1030

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Medication Errors and Reporting

POLICY:

The organization has a process to respond to actual or potential medication errors. All actual or potential errors identified will be documented through the hospital's risk management system via the On-Line Reporting System. All medication submitted reports will be reviewed by the Department Director or his/her designee as part of the hospital's improvement process. All adverse medication events requiring notification through external state, federal, USP or FDA channels will be reported.

DEFINITIONS:

1. Types of medication errors include:

   A. Prescribing~~Wrong: drug, dose, route, time, duration, patient, labeling,~~
   B. ~~frequency, instructions~~
   B. Order Communication
   C. Product labeling
   D. Package Nomenclature
   E. Compounding
   F. Dispensing
   G. Distribution
   H. Administration
   I. Education
   J. Monitoring
   K. Use~~Omission (not administered before next schedule dose due)~~
   L. ~~Transcription~~
   M. Others

PROCEDURE:

1 When a medication error occurs, the practitioner who identifies an error shall follow the procedure below:

   A. Notify the physician and evaluate the patient.

   B. Perform any necessary clinical interventions, within the patient care provider's scope of practice to reduce the negative effects of the identified error.

Effective Date: ~~09/23/09~~ (13) Ancillary Services
Pharmacy:
Medication Errors and Reporting
13-5071

APPROVED:

Medical Executive Comm.: ~~09/09/09~~

Board of Directors: ~~09/23/09~~

C. Record the medication as given on the Electronic Medication Administration Record (eMAR).

D. Record notification of physician in the medical record with any resultant orders.

E. Report the error in detail on the On-Line Reporting System.

F. All medication error reports will be forwarded to the appropriate department manager for review and follow up.

G. The Pharmacy Department will evaluate all medication errors and compile the following for review by the Performance Improvement, Pharmacy and Therapeutic, Patient Safety, and Medication Safety committees:

1. Types of error (set by National Coordinating Council for Medication Error Reporting and Prevention Index for Categorizing Medication Errors (NCC MERP)

2. Severity Ranking

3. Organization outcome from the error

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Medication Errors and Reporting

Descriptive Type: Revised

Document Number: 13-5071

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 07/30/09

Previous Dist. Date: 03/26/09

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~09/02/09~~	
MEC	~~09/09/09~~	
Board of Directors	~~09/23/09~~	

Effective Date: ~~09/23/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Blood Derivatives

POLICY:

The procurement, storage, control and distribution of all blood derivatives are managed by the Pharmacy Department with the exception of Rh immune globulin that is managed by the Laboratory. Guidelines for safe administration and monitoring of blood derivatives are provided by the Pharmacy & Therapeutics Committee.

DEFINITION:

Blood derivatives are pooled blood products such as albumin, gamma globulin, Rh immune globulin, factor VIII, factor IX, immune globulin and cytomegalovirus immune globulin.

PROCEDURE:

1. Blood derivatives are dispensed by the Pharmacy Department for individual patients in response to a physician order.

2. Blood derivatives are procured from wholesale supplier(s), but may also be obtained directly from manufacturers in the event of product shortages.

3. The Pharmacy Technician or Pharmacist will take note of the amount of blood derivatives on hand in the Pharmacy Department, exclusive of that quantity of albumin reserved for disaster. Based on this information, the Pharmacist of his/her designee will place an ~~telephone~~ order with the wholesale supplier.

4. All shipping cartons will be inspected for damage as with LVPs, and stock rotated to ensure use prior to expiration of products.

5. An "Albumin Usage Record" has been developed to capture utilization and usage information. ~~which is compiled and reported to the Pharmacy & Therapeutics Committee for evaluation.~~ When Albumin is dispensed, all albumin

will be dispensed with an "Albumin Usage Record" form which shall be completed by the nurse administering the albumin, returning the form to the Pharmacy Department.

~~6. Procedures for safe administration and monitoring are provided in the formulary and updated periodically.~~

~~7~~6. Reports of all significant adverse events involving blood derivatives will be reviewed by the Pharmacy & Therapeutics Committee.

~~8~~7. Orders for blood derivatives are subject to the same guidelines as other medications.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Blood Derivatives

Descriptive Type: Revised

Document Number: 13-5072

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~ Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Pharmacist's Therapeutic Intervention

POLICY:

All patients will have their drug profiles reviewed at the time a drug is prescribed and daily thereafter by a Pharmacist for potential drug interactions, therapeutic duplication and appropriateness of dosage.

PROCEDURE:

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

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

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

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

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

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~03/26/09~~

APPROVED:

Medical Executive Comm.: ~~03/11/09~~

(13) Ancillary Services
Pharmacy:
Pharmacist's Therapeutic Intervention
13-5074

Board of Directors: ~~03/25/09~~

Descriptive Name: Pharmacist's Therapeutic Intervention

Descriptive Type: Revised

Document Number: 13-5074

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 03/04/09

Previous Dist. Date: 01/26/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~03/04/09~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy & Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Patient Controlled Analgesia (PCA)

POLICY:

To provide safe and effective administration of opioid analgesics via a patient controlled infusion device; specific guidelines have been developed and approved by the Pharmacy and Therapeutics Committee. These guidelines are to be followed by professional staff when controlled analgesia is used. The use of smart pumps with Dose Error Reduction system (DERS) should be used when possible. Low concentration limits should be set as hard limits to reduce the potiential for error when using PCA therapy because of the significance of a low concentration alert during pump programming. If continuous PCA is ordered, End Tidal Carbon Dioxide (EtCO2) monitoring will be initiated. The EtCO2 monitoring system may be used for any patient receiving PCA at the discretion of the Registered Nurse for the first 12 hours of PCA use. EtCO2 assists in assessing early warning signs of respiratory depression for patients receiving supplemental oxygen.

PROCEDURE:

1. The physician's order must contain the following information:

   A. Name and strength of drug (converted to mg - mg per mL or mcg per mL)

   B. Bolus or loading dose (mg, mcg NOT mL)

   C. Continuous rate (mg per hour or mcg per hour)

   D. Incremental dose (mg or mcg)

   E. Lockout/delay time in minutes

   F. Instructions (respiratory rate, sedation, pain intensity, etc.)

Effective Date: 02/28/13

(13) Ancillary Services
Pharmacy:
Patient Controlled Analgesia (PCA)
13-5084

APPROVED:

Medical Executive Comm.: 02/13/13

Board of Directors: 02/27/13

2. Criteria will be applied to all patients for whom PCA is ordered. The following patients will not receive PCA:

   A. Pediatric patients [Under the age of ten (10)].

   B. Confused, agitated, combative patients.

   C. Patients experiencing extreme restlessness.

   D. Patients with altered level of consciousness (excluding post-operative patients with normal post-operative, transient altered sensorium.

   E. Mentally, intellectually, psychologically impaired patients.

3. The Pharmacy Department is to supply the drug for PCA use in pre-mixed syringes/bags. ~~Demerol (meperidine) is not recommended for PCA pump administration and should only be used when the patient is allergic to morphine or hydromorphone.~~

4. Any drug wastage from the PCA pump must be witnessed and appropriately documented by two (2) nurses and/or pharmacists.

5. Concurrent ordering of opioids or sedatives with PCA is to be avoided whenever possible. However practitioners may concurrently order opioids or sedatives if it is felt this is in the best interest of the patient. Special caution will be taken to decrease the possibility of over sedation. To avoid over sedation, opioids or sedatives ordered in addition to a PCA pump must be authorized by the physician who wrote the PCA orders. Patients receiving opioids or sedatives in addition to PCA will receive high-alert notification status for licensed independent practitioners caring for the patient, pharmacy and nursing staff.

6. Certain patients are at higher risk for complications and require particular attention to dosing:

   A. Patients with renal and/or hepatic insufficiency, delaying narcotic excretion.

   B. Patients with respiratory problems.

   C. Elderly or debilitated patients.

   D. Patients receiving other sedating drugs.

7. Narcan 0.4 mg, a syringe and normal saline are to be available on the unit where the patient is receiving the PCA.

8. Baseline vital signs will be obtain upon initiation of PCA: [respiratory rate, sedation level (Pasero Opioid Induced Sedation Scale), blood pressure, and pain scale] followed by every two (2) hours x 2, then every four (4) hours as long as the PCA drugs are being administered.
With each increase in dose adjustment; begin sequence of vital signs again.

9. Two (2) RNs are to verify orders and PCA pump settings when initiating a PCA pump infusion, changing any settings or medications, accepting a patient from another floor. The two clinicians are required to independently double-check the patient's identification, drug and concentration, PCA pump settings, and the IV line attachment before use (and before pump refill or programming change).

10. When coming on shift, the on-coming RN will double check the PCA medication and setting per physician orders.

    A. All staff administering PCA must receive education and training and demonstrate proficiency in:

        1. Identification and management of patient pain, including treatment with opioids and sedatives.

        2. Monitoring of the patient receiving PCA, including signs of over-sedation.

        3. Operational aspects of the PCA pump device, including programming, lockout, base rate and patient safety features of the device.

        4. Rescuing the patient from dangerous over-sedation.

11. PCA delivery is never to be given **"by proxy"**, meaning only the patient is to utilize PCA, unless <u>nurse-controlled PCA has been ordered</u>. In the instance of nurse-controlled PCA it is understood that the patient will not be participating in PCA for some portion (or the entire portion) of time the PCA is in use. Generally when nurse-controlled PCA is ordered, the nurse will control the PCA until the patient is able to perform this function.

        * <u>POST-OP PATIENTS</u> - Nurse-controlled PCA can be initiated per protocol for up to 12 hours post-op. Patient's that are unable to manage their PCA after 12 hours will require a physician's order to continue nurse-controlled PCA.

12. All staff will be educated about the dangers of administering PCA for the patient outside of the organization's approved nurse controlled analgesia protocol.

13. The patient, his/her family and support system and all visitors will be instructed on this institution's policy of not allowing **PCA by proxy** (anyone other than the patient or an authorized nurse is **NOT** to perform PCA). Education will include the dangers of others administering PCA (pressing the delivery device/button) and the harm that this may cause the patient. Written instructions will be given to the patient, family and visitors.

    A. Staff will assure that the PCA pump in use has the appropriate labeling indicating that only the patient should utilize the pump and the delivery device/button.

ASSESSMENT AND MONITORING:

1. Obtain baseline vital signs followed by vital signs every two (2) hours x 2, then every 4 hours thereafter. With each increase in dose adjustment, begin sequence of vital signs again.

2. Observe PCA patients for good pain control without over sedation.

    A. Check for patient arousal with verbal stimulation

    B. Monitor for respiratory depression. Check respirations for a rate less than 10.

    C. If patient is not arousable, respiratory rate is below 10 breaths per minute or has SBP below 90, hold the PCA, administer oxygen at 2 liters per minute administer naloxone, and contact the patient's physician.

3. Assess pain with pain scale and physical assessment.

4. Observe patient for untoward effects produced by medication, limiting patients desire to use the PCA pump effectively.

5. Assess and monitor the patient for post operative nausea and vomiting, which can occur due to opiate inducted stimulation of the chemoreceptor zone and vomiting center.

6. Inspect IV site, check PCA line to assure anti-siphon and/or non-return valve is patent and secured upon initial assessment of the patient at beginning of each shift and upon reassessment of the patient.

7. Pediatric patients above the age of 10 may receive PCA after RN assessment has determined understanding and competency of the patient management.

8. Monitor the patient for compliance with PCA protocol.
    A. If the patient appears not to understand the concept of PCA or has

difficulty using the deliver device, discuss with the patient's ordering physician transition to intramuscular injection analgesia.

B. If it is discovered that PCA by proxy (the patient's family, friends, visitors or anyone other than a healthcare professional authorized to provide PCA for the patient utilizing the delivery device for the patient), the PCA will be immediately discontinued and a discussion will be held with the patient's ordering physician to transition to other analgesic options.

EDUCATION:

1. Establish a trusting relationship with the patient to allow verbalization of fears.

2. Provide educational information to help reduce fears.

3. Explain clearly and simply how the PCA pump works.

4. Include family and /or significant others in teaching of why PCA has been chosen for the patient and the benefits of PCA.

5. Explain that **only** the patient is to utilize the PCA delivery device button. Education family and other support providers that they should inform nursing staff if they feel the patient is in pain, that they should NOT press the delivery device for the patient. That PCA delivery by anyone other than the patient or an authorized healthcare provider can lead to over-sedation and resultant harm to the patient.

DOCUMENTATION:

1. The RN should initiate documentation as appropriate for the patient situation on one of the following forms:

   A. PCA Record form #20002
   B. Recovery Documentation Form
   C. Post op Documentation Form
   D. MAR

2. Nursing documentation of PAC and EtCO2 values will be done in conjunction with vital signs.

3. If the patient refuses EtCO2 monitoring, the Registered Nurse will reinforce the need for the EtCO2. If the patient has a continuous PCA infusion rate and refuses EtCO2, a pulse oximeter will be initiated, the ordering Physician will be notified, and the refusal will be documented in the medical record by the Registered Nurse.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Patient Controlled Analgesia (PCA)

Descriptive Type: Revised

Document Number: 13-5084

Attachments: One

Author: ~~Lee Gardner, Interim Pharmacy Director~~ Stefanie Aflague, Pharmacy Manager

Typist: Carol Bradford

Creation Date: 08/10/2012

Previous Dist. Date: 09/23/10

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~02/06/13~~	~~Virtual Vote Approval~~
MEC	~~02/13/13~~	
Board of Directors	~~02/27/13~~	

Effective Date: ~~02/28/13~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy Department and Materials Management

FROM: Administration

SUBJECT: Pharmaceutical Vendors Representatives

I. PURPOSE:

To establish procedures and guidelines for the conduct of representatives of pharmaceutical companies.

I. PHILOSOPHY:

Tulare Regional Medical Center grants privileges to representatives of pharmaceutical companies to represent their companies and their products at the Hospital. Maintaining cooperative relationships between the Hospital and its vendors is encouraged and in the best interests of both the pharmaceutical companies and the Hospital. These policies and procedures are established and enforced to protect hospital staff from unnecessary interruptions which may interfere with patient care responsibilities and may compromise patient privacy and confidentiality. The promotion of products shall conform to the ethical standards and policies and procedures of the Hospital.

II. POLICY:

A. Representatives shall ~~register~~ contact ~~with~~ the Department of Pharmac~~yeutical Services~~ in advance of any activity at the Hospital.

B. Representatives shall have scheduled appointments prior to arriving at the Hospital.

C. Samples of medications shall not be distributed at any time or in any part of the Hospital.

D. Distribution of literature and promotional material is prohibited except as permitted by this policy.

E. Pharmaceutical company representatives are requested and expected to

comply with the policies and procedures herein. Non-compliance shall result in denial or suspension of further access to the Hospital by the individual representative or the company.

F. The ~~Director, Pharmaceutical Services~~Pharmacy Director ~~Manager,~~ shall be authorized to enforce ~~——————~~these policies.

II. Procedure

A. Upon arrival, pharmaceutical representatives shall register immediately ~~at Materials Management~~with security for all visits to the Hospital.

B. The representative's visit shall be logged by ~~the Materials Management~~security staff with the time of arrival and departure. ~~Staff~~ Security shall provide the representative with a pass to proceed to the Pharmacy.

C. Representatives shall visit the Hospital only during the following hours, Monday through Friday, 0900 ~~to1pm~~to 4pm, except by special arrangement through the ~~Director, Department of Pharmaceutical Services.~~ Pharmacy Director ~~Manager~~ or Pharmacy Buyer

D. After registering ~~at Material Management~~with security, the representative shall proceed to the Pharmacy.

E. Representatives shall log-in and sign the Pharmaceutical Representative Visit log in the Pharmacy.

F. Visits to other areas of the Hospital shall be by appointment only.

G. The representative shall enter on the Pharmaceutical Representative Visit log the names of the individuals with whom the representative has confirmed appointments.

H. Representatives shall not proceed to other areas of the Hospital without appointments.

~~I. The representative shall return the Security pass to the materials management staff who shall log the representatives' time of departure.~~

~~J. Pharmaceutical representatives shall register with the Department of Pharmaceutical Services on their first visit to the Hospital.~~

I.~~K~~. It is ~~preferable~~ required that appointments be made in advance; however, if this is the first visit, the representative shall be informed of the policies.

~~L. The representatives shall arrange an introductory interview with the Director, Pharmaceutical Services or designee.~~

~~M. The representative shall receive a copy of the policies and sign acknowledgment of receipt.~~

~~N~~J. Representatives shall provide their telephone numbers and other contact information.

~~O~~K. Representatives shall wear a badge identifying them by name and the company represented. In addition, the representative shall display the vendor security pass provided by ~~the~~ Security ~~officer~~. These identifications shall be worn and prominently displayed while in the Hospital.

~~P~~L. Representatives are prohibited from meeting with hospital or medical staff in patient care areas. Examples of patient care areas are nursing units, treatment rooms, surgical and recovery areas, and hospital hallways. Appropriate areas for meetings are offices, lounges or cafeterias. Meetings may take place in conference rooms with prior arrangement and approval.

~~Q~~M. Drug samples may not be distributed anywhere in the Hospital. Unsolicited drug samples for physicians' personal use may not be left in the Hospital.

~~R~~N. Representatives shall provide to the ~~Director of Pharmaceutical Services~~Pharmacy Director ~~Manager~~, or designee, examples of all promotional brochures, pamphlets, literature reprints, and charts prior to disseminating these in the Hospital.

~~S~~O. Upon request, literature may be provided directly to members of the medical staff.

~~T~~P. Such literature shall not be otherwise distributed on the Hospital premises except as authorized by the ~~director of Pharmaceutical Services~~Pharmacy Director ~~Manager~~ or designee.

~~U. All representations of products shall include information regarding its formulary status and availability at the Hospital.~~

~~V~~Q. Representatives are requested to inform the Department of Pharmaceutical Services of all new information regarding their products and their uses.

~~W~~R. New information may be dropped or mailed to the Department regularly.

~~X~~S. Other specific information may be requested to assist in the objective comparison and evaluation of products' safety, efficacy and pharmacoeconomic value.

~~Y~~T. Pharmaceutical representatives shall not offer nor provide gifts of any significant value to members of the hospital staff. Common promotional items, such as pens, pencils, and pads, are acceptable.

~~Z~~U. Educational programs may be presented at the Hospital after review and approval by the designated member of the pharmacist staff. A pharmacist should attend the specific presentation to provide information regarding the products' status and availability at the Hospital.

~~AA~~V. Non-compliance with these policies and procedures may result in revocation of the representative or the company's privileges to visit or have access to the Hospital.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Pharmaceutical Vendors Representatives

Descriptive Type: 13-5086

Document Number: Revised Policy

Attachments: None

Author: ~~Tom Nguyen, Interim Pharmacy Director~~Stefanie Aflague, Pharmacy Director ~~Manager~~

Typist: Julie Gresham

Creation Date: 08/10/10

Prev. Dist. Date: 09/27/07

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Look-alike / Sound-alike Drugs

PURPOSE:

~~**National Patient Safety Goal: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.**~~

Confusing drug names is a common system failure. Unfortunately, many drug names can look or sound alike other drug names, which may lead to potentially harmful medication errors. Increasingly, pharmaceutical manufacturers and regulatory authorities are taking measures to determine if there are unacceptable similarities between proposed names and products on the market. ~~But factors such as poor handwriting or poorly communicated oral prescriptions can exacerbate the problem. In 2001, The Joint Commission published a Sentinel Event Alert on look-alike and sound-alike drug names. This NPSG recognizes that h~~Health care practitioners and organizations need to be aware of the role drug names play in medication safety as well as system changes that can be made to prevent errors. The table below provides a list of the most problematic look-alike and sound-alike drug names for Tulare Regional Medical Center settings.

This summarizes the organizational strategies we use to help prevent medication errors.

~~SALA~~Reducing look alike-sound alike medication errors for individual agents.

- "Tall man" lettering is a strategy used for many of these and are listed. This lettering convention is used in our electronic system/pharmacy to help differentiate between drugs that look similar when read.
- For inpatients, medications are profiled on the automated ~~PYXIS~~ dD~~d~~ispensing machines once reviewed and verified by the Pharmacist.
- The "read back" procedure helps prevent errors in ~~verbal~~ telephone orders.

Effective Date: ~~09/27/12~~ (13) Ancillary Services
Pharmacy:
Look-alike / Sound-alike Drugs
13-5096

APPROVED:

Medical Executive Comm.: ~~09/12/12~~

Board Of Directors: ~~09/26/12~~

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

~~2011-2012~~2018-2019
Look-Alike / Sound Alike Drug List

Drug Name with Tall Man Letters	Confused with
ALPRAZolam	**LOR**azepam-clonaze**PAM**
AVINza	**INV**anz
buPROPion	**busPIRone**
busPIRone	buPROPion
carBAMazepine	**OXcarbazepine**
ceFAZolin	cefoTEtan-cefOXitin-cefTAZidime-cefTRIAXone
cefOXitin	ceFAZolin-cefoTEtan-cefTAZidime-cefTRIAXone
cefTAZidime	ceFAZolin-cefoTEtan-cefOXitin-cefTRIAXone
cefTRIAXone	ceFAZolin-cefoTEtan-cefOXitin-cefTAZidime
CeleBREX	CeleXA
CeleXA	CeleBREX
chlordiazePOXIDE	chlorproMAZINE
chlorproMAZINE	ChlordiazePOXIDE
clonazePAM	cloNIDine-LORazepam
DEPO-Medrol	SOLU-Medrol
diazePAM	dilTIAZem
dilTIAZem	diazePAM
DOBUTamine	DOPamine
DOPamine	DOBUTamine
DULoxetine	FLUoxetine-PAroxetine
ePHEDrine	EPINEPHrine
EPINEPHrine	ePHEDrine
fentaNYL	SUFentanil
FLUoxetine	DULoxetine-PAroxetine
glipiZIDE	glyBURIDE
glyBURIDE	glipiZIDE
HumaLOG	HumuLIN
HumuLIN	HumaLOG
hydrALAZINE	hydroCHLOROthiazide-hydrOXYzine-HYDROmorphone
hydroCHLOROthiazide	hydroxyzine- hydrALAZINE
HYDROmorphone	hydrOXYzine-hydrALAZINE-morphine
hydrOXYzine	hydrALAZINE-HYDROmorphone-hydroCHLOROthiazide
inFLIXimab	riTUXimab
INVanz	AVINza
KlonoPIN	cloNIDine
LaMICtal	LamISIL
LamISIL	LaMICtal
lamiVUDine	lamoTRIgine
lamoTRIgine	lamiVUDine
levETIRAcetam	levOCARNitine-levoFLOXacin
levOCARNitine	levETIRAcetam
levoFLOXacin	levETIRAcetam
LORazepam	ALPRAZolam-clonazePAM
medroxyPROGESTERone	methylPREDNISolone
methylPREDNISolone	medroxyPROGESTERone
metOLazone	methIMAzole
morphine	HYDROmorphone
niCARdipine	niMODipine-NIFEdipine
NIFEdipine	niMODipine-niCARdipine
NovoLIN	NovoLOG
OXcarbazepine	carBAMazepine
oxyCODONE	HYDROcodone-OxyCONTIN
OxyCONTIN	oxyCODONE
PARoxetine	FLUoxetine-DULoxetine
prednisoLONE	predniSONE
predniSONE	prednisoLONE
QUEtiapine	OLANZapine

rif**AMP**in	rif**AXIM**in
rif**AXIM**in	rif**AMP**in
Risper**DAL**	r**OPINIRole**
risperi**DONE**	r**OPINIR**ole
ri**TUX**imab	in**FLIX**imab
TEGretol	**TREN**tal
TRENtal	**TEG**retol
ZOLMitriptan	**SUMA**triptan
Zy**PREXA**	Zyr**TEC**
Zyr**TEC**	Zy**PREXA**
~~**ALPRAZolam**~~	~~**LOR**azepam~~
~~bus**PIR**one~~	~~bu**PROP**ion~~
~~ce**FAZ**olin~~	~~cefo**TE**tan~~
~~ce**FAZ**olin~~	~~cef**OX**itin~~
~~ce**FAZ**olin~~	~~cef**TAZ**idime~~
~~ce**FAZ**olin~~	~~cef**TRIAX**one~~
~~Cele**BREX**~~	~~Cele**XA**~~
~~clonaze**PAM**~~	~~**cloNIDine**~~
~~clonaze**PAM**~~	~~clo**ZAP**ine~~
~~clonaze**PAM**~~	~~**LOR**azepam~~
~~**DOBUT**amine~~	~~**DOP**amine~~
~~e**PHED**rine~~	~~**EPINEPH**rine~~
~~glipi**ZIDE**~~	~~gly**BURIDE**~~
~~Huma**LOG**~~	~~Humu**LIN**~~
~~Humu**LIN**~~	~~Huma**LOG**~~
~~hydr**ALAZINE**~~	~~hydr**OXY**zine~~
~~medroxy**PROGESTER**one~~	~~methyl**PREDNIS**olone~~
~~morphine~~	~~**HYDROmorphone**~~
~~ni**CAR**dipine~~	~~**NIFE**dipine~~
~~Novo**LIN**~~	~~Novo**LOG**~~
~~predniso**LONE**~~	~~predni**SONE**~~
~~qui**NID**ine~~	~~qui**NINE**~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Look-alike / Sound-alike Drugs

Descriptive Type: Revised Policy

Document Number: 13-5096

Attachments: None

Author: ~~Abby Adesanya, Pharm.D~~Stefanie Aflague, Pharmacy Director

Typist: ~~Abby Adesanya/Gillian Busch~~Stefanie Aflague

Creation Date: 05/29/12

Previous Dist. Date: 04/23/09

Committee Review:	Approval Date:	Comments:
P&T Committee	~~06/01/12~~	
Pharmacy & Therapeutics Comm	~~08/24/12~~	
MEC	~~06/13/12~~	
MEC	~~09/12/12~~	
Board of Directors	~~09/26/12~~	

Effective Date: ~~09/27/12~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Parenteral Nutrition

I. PURPOSE:

The purpose of this policy is to provide efficient and cost-effective nutritional support for Tulare Regional Medical Center (TRMC) patients on parenteral nutrition program through a multi-disciplinary team effort.

II. POLICY STATEMENT:

It is the policy of the Nutritional Support Team (NST – consists of Pharmacist and Dietitian) to adjust and monitor parenteral nutrition therapy when a physician writes "TPN/PPN per pharmacy" or "TPN/PPN per protocol" or enters electronically. This order then enables the pharmacists to ~~write~~ enter orders on the physician's order under the scope of the protocol.

III. PROCEDURE:

A. Upon receiving a physician order to request for Nutritional Support Assistance (~~All TPN solution will begin at 1600 hours daily;~~ All changes, additions, deletions must be received by 1600 hours; All new orders received after 1600 will be initiated the following day; the ordering physician will be notified. If appropriate, pharmacist may start Procalamine (3% Amino Acid and 3% Glycerin Injection with Electrolytes) until the following day~~)~~.

1. Any physician may request the NST to initiate or adjust parenteral nutrition for his/her patients by writing/entering an order indicating so. The physician should indicate the goals of therapy, reasons for parenteral versus enteral nutrition, nutrition via peripheral or central vein, and the duration of nutritional therapy. Dietitian will perform

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Effective Date: 02/25/10

(13) Clinical Services Pharmacy: Parenteral Nutrition 13-5101

APPROVED:

Medical Executive Comm.: 0210/10

Board Of Directors: 02/24/10

an initial assessment of the patient to determine whether patient shall be receiving enteral versus parenteral nutrition.

2. ~~All TPN/PPN orders must be ordered on a standardized TPN/PPN order form.~~

~~3~~2. If the required changes constitute a medical emergency (i.e. removal of potassium due to hyperkalemia, or phosphate due to hyperphosphatemia), nursing staff will discontinue the current bag. Dextrose 10% or other appropriate IV solution as prescribed will be infused at the prescribed rate until pharmacy can supply the replacement solution.

~~4~~3. In the event the pharmacy department is closed when a TPN order is received, the nursing staff will get an order to hang dextrose 10% at the prescribed rate. Initiation of TPN is never a "STAT" order. In the morning when the pharmacist arrives, the TPN order is reviewed for preparation.

5. Patients deemed clinically unstable or too complex will be referred back to the requesting physician for primary care. NST will then serve in as an "advisory" capacity only.

B. Indications for Parenteral Nutrition

1. The following indications necessitate the delivery of parenteral nutrition therapy:

- NPO over 5 to 7 days
- Significant poor enteral intake and may have 10-20 percent weight loss
- GI Diseases: anatomic or functional loss of GI integrity such as:
  - Short bowel syndrome
  - Post GI surgery
  - Enterocutaneous fistulas with > 500 ml output/day
  - Prolonged bowel obstruction or prolonged ileus
  - Malabsorption syndrome
  - Substantial GI bleeding
  - Crohn's disease
  - Cystic fibrosis
  - Obstruction
  - Active inflammatory bowel disease
  - Intractable nausea/vomiting

- Intractable diarrhea > 2 L/day
- Severe mucositis, esophagitis, or enteritis
- Acute pancreatitis

Depending on the type and location of dysfunction of the GI tract, enteral feedings may still be appropriate.

2. Required bowel rest.

3. Intolerance to oral nutritional therapy: extended hyperemesis gravidarum (naso-duodenal enteral feeds may be tolerated), severe nausea/vomiting or stomatitis due to chemotherapy, severe chronic diarrhea unresponsive to appropriate oral or enteral feeds, patient refusal to receive or intolerance to appropriate oral or enteral feeds.

4. Nutritional deprivation where appropriate oral or enteral feeds are not tolerated or inadequate.

5. Hypermetabolic states where appropriate oral or enteral feeds are not adequate or tolerated such as multi-organ failure, sepsis syndrome, or AIDS.

6. Neurotrauma where appropriate oral or enteral feeds are not adequate or tolerated.

7. Malignant disease where appropriate oral or enteral feeds are not adequate or tolerated (i.e. radiation enteritis). The goal of therapy is to provide adequate nutrition to promote a positive nitrogen balance and support the inherent homeostasis and immune system of the patient.

C. Contraindications

1. Functional GI tract
2. Duration < 5 days
3. Prognosis

D. Nutrition Evaluation

1. Each patient will be evaluated individually, with the following parameters used to determine nutritional status:

- Medical history and current diagnosis
- Nutrition history

- Body size (muscle and fat stores), body surface area
- Percent ideal body weight
- Percent deviation from usual weight
- Visceral/hepatic transport proteins
- Pertinent laboratory values
- Assessment of estimated or measured energy, protein, fluid and micronutrient needs.

E. Calculation of Nutritional Requirements

1. Non-protein calories (per kilogram actual body weight per day)

- Maintenance 25-30 kcal/kg
- Moderate stress 30-35 kcal/kg
- Severe stress 35-45 kcal/kg

2. Protein (per kilogram actual body weight per day)

- No stress 0.7-0.8 gm/kg/day
- Mild stress 0.8-1.0 gm/kg/day
- Moderate stress 1.0-1.5 gm/kg/day
- Severe stress 1.5-2.0 gm/kg/day

3. Calculate Maximum Glucose Tolerance (MGT) = 4.5 mg/kg/minute

4. Calculate Maximum Lipid Infusion: 2.5 gm/kg/day

5. Calories for Initiating Nutrition Support

- Calories Needed:
  BEE (in kilocalorie per day)

  Male: Kcal = 66.47 + 13.75(wt in kg) + 5.0(ht in cm) – 6.76(age in yrs)

  Female: Kcal = 655.10 + 9.56(wt in kg) + 1.85(ht in cm) – 4.68(age in yrs)

- AEE = BEE x (activity factor) x (injury factor)

Activity factor		*Injury factor*	
Confined to bed	1.2	Surgery	1.2
Out of bed	1.3	Skeletal trauma	1.3
		Sepsis	1.6

Severe burn	2.1
CA therapy	1.3
AIDS	1.6
Pulmonary	1.3
Liver	1.3

- Alternative method for approximation of actual caloric needs:

No stress, minimal activity	28 kcal/kg/day
Mild stress	30 kcal/kg/day
Moderate stress	35 kcal/kg/day
Severe stress	40 kcal/kg/day

6. Fluid Requirements
   - If there are no fluid restrictions, total fluids should = 35-50 ml/kg/day IBM.
   - Fluid requirements = 100 ml/kg for the first 10 kg body weight + 50 ml/kg for the next 10kg body weight + 20 ml/kg for each kilogram greater than 20

     or

     1500 ml/day + 20 ml/kg for each kg over 20

     or

     1500 ml/m^2/day, using BSA
   - Additional fluid volume is replaced if the patient has a fever. Then general range is 300 to 700 ml per day for each degree F. above normal.

7. Electrolytes
   - The composition of each formulation will be standard if no serum electrolyte abnormalities exist, and daily adjustments made in accordance with the patient's actual laboratory values if necessary.
   - Average daily adult requirements:

Sodium	(136-145)	60-150meq/day (3-4meq/kg/day)
Potassium	(3.5-5.1)	90-240meq/day (initially 1.2-1.5 meq/kg/day)

Phosphorus	(2.5-4.9)	20-40 meq/day (15-30 mmoles/day)
Magnesium	(1.8-2.4)	8-24 meq/day (initially 0.3 meq/kg/day)
Calcium	(8.8-10.3)	10-25 meq/day
Chloride	(98-107)	60-150meq/day
Acetate	(23-29)	20-80 meq/day

Rule of thumb: Keep the product of Ca^{++} and PO_4^{-2} <300 or the sum <30.

- Parenteral electrolyte recommendations:

Grant	
Potassium	80-100 meq
Sodium	80-100 meq
Phosphorus	7-10 mmol/1000 kcal
Magnesium	0.25-0.35 meq/kg/d
Calcium	0.2-0.3 meq/kg/d
Chloride	Equal to sodium to prevent acid-base disturbances

Schlictig and Ayers	
Potassium	70-100 meq
Sodium	70-100 meq
Phosphorus	20-30 mmol
Magnesium	15-20 meq
Calcium	10-20
Chloride	

8. Calorie to Nitrogen Ratio:

   - Generally accepted ratio is 150-300 to 1 as this insures sufficient calories for anabolism and proper nitrogen utilization in protein synthesis in critically ill individuals in stressed state (NPC:N ratio 70-125).

9. Vitamins, Minerals, and Other Additives

   - Multivitamins (MVI-Adult 10 ml) will be added to the formulation necessary to meet the recommended daily allowance (RDA), as determined by the Food and Nutrition Board of the Nutrition Research Council National Academy of Science.

- Trace elements (1 ml), MTE-4, will be added to the formulation daily which contains:

Zinc	5 mg	Copper	1 mg
Manganese	0.5mg	Chromium	10 mcg

  Zinc and chromium are excreted renally. Their dose should be reduced or deleted with decreased renal function. With hepatic failure or severe biliary disease, copper and manganese should be reduced or deleted.

  Patients on parenteral nutrition for more than ≥ 30 days, selenium 60 mcg will be added to the formulation.

- Insulin:
  Daily regular insulin can be placed into parenteral nutrition solutions. It is advisable only to place insulin in parenteral nutrition solutions when the patient's caloric intake and insulin requirements are stable. Otherwise this may lead to waste of parenteral nutrition solutions if requirements should change abruptly.

- Histamine-2 antagonists can be placed in parenteral nutrition solution with less cost to the patient than administering them intermittently.

F. Initiation of Parenteral Nutrition

1. Baseline laboratory values required and to be ordered if necessary:

   - Chem admit or baseline (if not done within the last 2-3 days), Na^{+}, K^{+}, Cl^{-}, HCO_3, glucose, BUN, serum creatinine, protein, albumin or pre-albumin, bilirubin, alkaline phosphatase, SGOT, SGPT, LDH, uric acid, Ca^{+2}, PO_4^{-}, Mg^{+2}, triglycerides, cholesterol, CBC with differential, and PT/PTT/INR.

   - Other studies which may be ordered:
     Transferrin, total iron-binding capacity (TIBC), serum ferritin, liver function test, pancreatic enzymes, and 24-hour urinary urea nitrogen.

2. Initiation of nutritional therapy

   - Start standard glucose-system infusion as follows:

Day one	1000 ml over 24 hours
Day two	2000 ml over 24 hours
Day three	3000 ml over 24 hours, or to desired rate

- Maintenance IV rate will also be decreased so as to deliver the same fluid load per 24 hours, if not otherwise indicated by physician in charge.

3. Initiation of fat emulsion

   - In general, patients with a history of allergic reaction to eggs, egg products, chickens, or chicken feathers should not receive fat infusions. This is because the emulsifier in these preparations is egg-yolk phospholipids.

   - Prior to starting fat emulsion, baseline triglycerides and cholesterol must be drawn.

   - Fat emulsion 10% may be hanged as a piggyback over 24 hours or be included in the TPN formulation and run continuously.

4. Peripheral versus central nutrition formulations

   - In some patients requiring parenteral nutrition, central catheter placement is either not feasible or necessary, and thus the formulation is then infused via peripheral vein. In this case the only limiting factor is solution tonicity. Solution with an osmolality of $\geq$ 900 generally require central access, peripheral access is difficult to maintain for > 3-4 days.

   - Nutritional formulations with final dextrose concentrations greater than 10% are usually too irritating for administration by peripheral vein, therefore, a central route is preferred.

   - Fat emulsions are isotonic and thus administration by either peripheral or central vein is acceptable.

5. Infusion rate

   - To avoid hyperglycemia, solutions with a high dextrose concentration should be started at a minimal rate. Advance to the full rate slowly over a 2-3 day period.

- In tapering patients quickly off high dextrose parenteral nutrition, it is recommended to halve the rate x 4 hours then discontinue the solution. May opt to check a blood glucose level 1 to 2 hours after the solution is discontinued. If the patient is receiving insulin with the parenteral nutrition or is on a sliding scale of insulin take the estimated duration of effect of insulin and the timing of the last dose of insulin into account. May wish to taper the solution more slowly. Along with the above, consider the effect of meals and tube feedings.

G. Parenteral Nutrition Assessment

1. The following items should be included in the nutritional assessment of patients being considered for parenteral nutrition therapy.

   - Allergies
   - Age, sex, height, weight
   - Problem list
   - Degree of malnutrition or weight loss per time period prior to admission
   - Oral nutritional intake prior to admission (nutrition history)
   - Laboratory values available
   - Current intravenous fluids and rate
   - Estimated fluid, caloric, and protein requirements
   - Proposed nutritional formulation and initiation procedure
   - Order formulation in final dextrose, final amino acid and total ions per liter regardless of bag size.

2. Routine monitoring

   - All patients will be monitored daily by the NST.
   - Minimum RD monitor 2 x weekly and by consult.

H. Routine Monitoring of Patients Receiving Parenteral Nutrition by the NST:

1. Laboratory values:

   - A laboratory panel consisting of serum Na^{+}, K^{+}, Cl^{-}, HCO_3^{-}, BUN, creatinine, glucose, Ca^{+2}, Mg^{+2}, and PO_4^{-} will be drawn daily for the first 3 days or until desired infusion rate is attained and the patient appears stable. This should then be repeated at least 3times a week as long as the patient is on

parenteral nutrition.

- Baseline serum triglycerides, cholesterol, liver function tests, serum albumin, CBC with differential, and PT/PTT/INR. Then monitored once weekly.

- Other laboratory values may be monitored.

2. Fluid volume status

- Strict intake/output
- Daily weights
- Clinical signs of peripheral edema, pulmonary edema, or third spaced fluid (e.g., ascites).

3. Glucose tolerance

- Monitor serum glucose daily until stable then 3 times weekly.

4. Monitoring for possible infection or sepsis secondary to parenteral nutrition

- Check daily temperature/vital signs every 8 hours
- Monitor white count
- Observe IV site for possible infection

I. Formulation Adjustments and Discontinuation

1. Formulation adjustments

- The parenteral nutrition formulation will be reviewed and adjusted based on the patient's clinical status and laboratory values. This may be done on a daily or every-other-day basis depending on when laboratory values are drawn and how stable the patient is on the current formulation.

- Abnormalities that are not correctable within the first 72 hours will be reported to the physician caring for the patient.

- It may be necessary to institute electrolyte "IVPB" (potassium, magnesium, phosphate, etc.) to bring abnormal serum electrolytes into the normal range before and during parenteral nutrition. The following limitations will be placed on each IVPB: potassium – no more than 40 meq;

magnesium – no more than 2 grams; and phosphate – no more than 20 mM.

- Recommendations for formulation adjustments:
  Alter no more than:
  Magnesium – 8 meq/L
  Phosphate – 10 mM/L
  Calcium – 5 meq/L

- Greater adjustment, if needed, can be achieved by use of electrolyte "IVPB".

2. Common complications seen related to parenteral nutrition

- Metabolic alkalosis (i.e., increased CO_2)
  - Decrease acetate concentration, and/or
  - Increase chloride concentration
  - Induced hypokalemia should correct with normalization of alkalosis, therefore no additional potassium will be needed.

- Metabolic acidosis (i.e., decreased CO_2)

  - Increase acetate concentration, and/or
  - Decrease chloride concentration
  - Induced hyperkalemia should correct with normalization of acidosis, therefore reduction in formulation potassium may not be needed.

- Hyponatremia (i.e., decrease sodium)

  - May reflect fluid retention or overload. If so, initiate fluid restriction
  - Increase sodium concentration cautiously in formulation if patient is determined to be sodium depleted.
  - Some major causes of hyponatremia are: excess water, CHF, SIADH, ascites, diarrhea, drains, vomiting, and NG suction.
  - Carefully monitor patient weight and intake/output.

- Uremia (i.e., increasing BUN)

  - Decrease amino acid delivery by decreasing rate, or

- Decrease amino acid concentration, or
- Start essential amino acid formulation
- Carefully monitor renal status and BUN/SCr ratio

- Abnormal liver enzymes

  - Possibly be caused by fat and/or glucose overload (i.e., excess calories)
  - Recheck serum triglycerides and cholesterol
  - Eliminate fat emulsion administration, or reduce to one unit per week if patient has documented end stage liver failure.

J. Formulation discontinuation (written as physician verbal order)

1. Discontinuation of glucose-system parenteral nutrition can be achieved by slowly decreasing administration rate in a reverse manner similar to initiation of therapy, or change to 10% dextrose infusion.

2. Lipid-system parenteral nutrition can be stopped at any time.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Parental Nutrition

Descriptive Type: ~~New~~Revised Policy

Document Number: 13-5101

Attachments: None

Author: ~~Tom Nguye~~Stefanie~~n~~ Aflague

Typist: ~~Julie Gresham~~Stefanie Aflague

Creation Date: 01/28/10

Revision Date: 4/24/18

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
P&T Committee	~~02/03/10~~	
MEC	~~02/10/10~~	
Board of Directors	~~02/24/10~~	

Effective Date: ~~02/25/10~~

Forward To Intranet: Policy Binders (PBX and Administration) and Post on

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

DELETE

TO: Pharmacy, Medical Staff and Clinical Services

FROM: Administration

SUBJECT: Medication Administration Check (MAK) Downtime Procedure

POLICY:

It is the policy of Tulare Regional Medical Center to provide a policy and procedure that will be followed when the Medication Administration Check (MAK) system is not available. If the MAK system is not accessible, contact the IS Department. If the system cannot be brought back within 30 minutes, Information Systems will contact the Director of Pharmacy and the Chief Nursing Officer. The Chief Nursing Officer will notify the Nursing Supervisors and Nursing Managers that the MAK downtime policy is now in effect. All administration of meds will revert to a manual system (Code Brown).

PROCEDURE:

1. In the event of a total network downtime, the Downtime Paper Medication Administration Record (MAR) will be printed and distributed by pharmacy staff or nursing supervisor as follows:
    a. Access intranet from start tab located in the left lower corner or your desktop icon
    b. Click on the “login” tab on the top menu.
    c. “System Login” will appear and request your Window’s sign in information.
    d. Several picture icons appear, click on the “Department Toolbox” (red toolbox).
    e. Then scroll down and find “Pharmacy Tools”
    f. Under this title you will find “Downtime Mar Archive” click on it. This folder will contain each nursing unit.
    g. Double click on the first folder and the file will open.
    h. Click print to print the MAR for that nursing unit.
    i. Click on the next nursing unit and print, repeating this for each nursing

floor.

2. MAR's will be printed to each unit.
    a. Nurses will pick up the MAR's for the patients they are assigned.
    b. This MAR will be utilized at TRMC through the downtime hours. Clinicians shall document in writing doses administered on the printed MAR.
    c. Nursing staff will continue to scan all physician orders to the pharmacy as long as the pharmacy confirms that the orders are being received. If the pharmacy scanner is down, the orders will be brought to the pharmacy in person.
    d. Once the system is back up all paper MAR's will be placed in the patients chart as part of the permanent record.
    e. Once pharmacy enters all orders during the downtime, nursing will document electronically in MAK all doses administered during downtime (i.e. "recover" all downtime doses in MAK). The purpose of this is to ensure a complete electronic medical record and ensure proper charges for medications. The designated personnel for each unit will make the assignment for recovery of the medications in MAK.
    f. Retrospective electronic Medication Administration Record (eMAR) documentation will be completed by the nurse currently responsible for the patient when the system becomes available.
    g. The clinician responsible for documenting retrospectively on the eMAR after a downtime will be prompted for the actual administration time when charting; a Downtime Recovery window will appear for all occurrences that were scheduled during the downtime – the clinician will be able to enter the actual time the medication was given in the window
    h. Retrospective eMAR documentation by primary care clinician will not take place if the downtime is longer than twelve hours, the information will be reduced to electronic format by a task team.
    i. A task team will be developed and all doses that were to be administered during the downtime that were documented on the paper MAR will be charted against the appropriate administration time when the system becomes available.
    j. Once all dose documented on paper MAR's are fully documented in MAK, the paper MAR's will become a permanent part of the patient's medical record stored in the patient chart.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

POLICY/GUIDELINE MANUAL

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Medication Administration Check (MAK) Downtime Procedure

Descriptive Type: New Policy

Document Number: 15-5106

Attachments: None

Author: MAK Team

Typist: Abby Adesanya / Gillian Busch

Creation Date: 01/31/12

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P & T Committee	02/01/12	
MEC	02/08/12	
Board of Directors	02/22/12	

Effective Date: 02/23/12

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Pharmacy Department

FROM: Administration

SUBJECT: Reporting Chemical, Mental or Physical Impairment of a Licensed Pharmacy Employee to the Board of Pharmacy

I. PURPOSE:

The purpose of this policy is to comply with a California State Board of Pharmacy regulation (CA Bus. & Prof. Code 4104) requiring the pharmacy to reporting chemical, mental or physical impairment of a Licensed Pharmacy Employee to the Board of Pharmacy.

II. PROCEDURE

Every pharmacy shall report and provide to the Board of Pharmacy any board licensed pharmacy personnel that:

- Admit to chemical, mental, or physical impairment affecting his or her ability to practice. Or demonstrate evidence of such impairments.
- Admit to the theft, diversion, or self-use of a prescription drug. Or demonstrate evidence of theft, diversion or self-use.
- Termination of a licensed employee for any of the above impairments or evidence of prescription drug theft, diversion or self-use.

The report shall be made in writing to the Board of Pharmacy within fourteen (14) days. The report shall be made in sufficient detail indicating the important facts:

- An estimate of the type and quantity of all prescription drugs involved.
- The timeframe over which the losses are suspected.

Effective Date:	(13)	Ancillary Services Pharmacy:
APPROVED:		Reporting Chemical, Mental or Physical Impairment of a Licensed Pharmacy Employee to the Board of Pharmacy
Medical Executive Comm.:		13-5109
Board Of Directors:		

- The date of the last controlled substances inventory.

Any licensed pharmacy employee who is impaired that affects his or her ability to practice or evidence of prescription drug theft, diversion or self-use shall be addressed procedurally as specified in hospital policy 15-2065 Drug and Alcohol: Employee Testing.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Reporting Chemical, Mental or Physical Impairment of a Licensed Pharmacy Employee to the Board of Pharmacy

Descriptive Type: ~~New~~Revised Policy

Document Number: 13-5109

Attachments: None

Author: ~~Lee Gardner, PharmD., Interim Director, Pharmacy~~Stefanie Aflague, Pharmacy Director

Typist: ~~Lee Gardner/Gillian Busch~~Stefanie Aflague

Creation Date: 11/05/12

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Committee Review and Approval:	Approval Date:	Comments:
Pharmacy & Therapeutics Comm.	~~12/07/12~~	
MEC	~~01/09/13~~	
Board of Directors	~~01/23/13~~	

Effective Date: ~~01/24/13~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Computerized Physician Order Entry (CPOE)

I. SCOPE:

This policy covers all CPOE orders placed at Tulare Regional Medical Center.

II. PURPOSE:

1. To ensure all orders are properly entered into the computer, communicated to nursing staff and executed as intended.

2. To outline the process of communication between the ordering provider, RN staff, Ancillary and Pharmacy for all CPOE processes.

3. To identify the responsibilities of the ordering Provider, RNs, Unit Secretaries and Pharmacists in the CPOE processes.

4. To prevent errors of omission, decrease transcription errors and enhance patient safety.

5. To identify and outline the order entry process when a patient is pending admission to a unit utilizing CPOE process.

III. Provider Ordering Responsibilities:

A. ORDER ENTRY:

1. Ordering Provider and any physicians trained in CPOE will directly enter all orders for the patient through the facility electronic order entry system. Handwritten or verbal orders from these groups are not to be given to the nursing/ancillary staff except with the following scenarios:

a. A patient emergency.

b. The ordering provider is performing a clinical procedure.

c. The facility electronic order entry system is not functional.

2. Telephone Orders:

a. Telephone orders will only be accepted when the ordering provider cannot access the facility electronic order entry system.

b. The ordering provider will authenticate all telephone or verbal orders on the Physician's Order Sheet in the chart and/or the facility electronic order entry system signature required process.

c. The authentication of orders by another provider. Refer to Hospital policy #12-1024.

3. Admission, Diagnosis and Condition:

a. The patient's admission location, diagnosis and condition will be entered using the General Admitting Orders or individual orders by the ordering provider.

4. Admission from ED to Unit:

a. Once admission orders are placed by the attending provider, all ED generated orders must be reviewed.

5. Medication Order Renewals:

a. Medications are ordered, renewed, and administered in accordance with State and Federal regulations and hospital policy #12-1024. Medications are subjected to existing "Automatic Stop Orders Policy-13-5083".

Note: All active medications are reviewed and reordered at the time of surgery, delivery, and transfer to different level of care.

B. COMMUNICATION OF ORDERS:

1. Ordering provider will communicate verbally with a nurse if they have entered a STAT (within 5 minutes) or Now (within 15 minutes) order.

2. The ordering provider needs to be aware that the nurse will check the New Orders Received (NOR) link routinely every 2 hours (see nursing responsibilities below). If an order needs more immediate attention,

the ordering provider will verbally communicate to the nurse that order(s) were entered that would require attention before the routine check for order(s).

C. PROTOCOLS AND WORKSHEETS:

1. DNR:

All orders related to DNR will be written on the paper POLST Form by the attending physician and the form is placed in the front of the patient's chart.

2. Heparin Physician Order Set:

The ordering provider will enter the order details in Heparin Therapy order set will continue on paper at this time.

3. TPN/PPN:

TPN/PPN orders will be written on the Parenteral Nutrition Order Sheet. The copies will be forwarded as usual to nursing and Pharmacy. An order for TPN/PPN specifying an administration. Required lab orders associated with the TPN/PPN can be entered via the order entry process.

4. Order Not Found in CPOE:

If individual orders are not found in CPOE, order must be placed on paper order form.

D. ADMISSIONS, TRANSFERS AND DISCHARGES:

1. Ambulatory Care Patients:

Ambulatory care patients will have their pre-op orders completed in CPOE. Service authorization will follow current pre-authorization process.

E. TRANSFERS:

1. Initiation of Transfer request:

a. The ordering provider will enter an order for a transfer request (Transfer order).

b. Admitting registration will receive a call and/or requisition on their printer. Bed Coordinator/Supervisor will initiate the request and look for an available bed.

c. The unit secretary will then process this change of patient location in system.

2. Transfer to same level of care:

Existing orders remain active.

3. Transfer to a different level of care:

a. Patients transferred to a different level of care require a new set of orders.

b. All existing orders at the time of transfer need to be reconciled reviewed, discontinued or reordered.

4. Transfer from Post Anesthesia Care Unit:

a. Anesthesiologist Orders - Post Operative:

i. All orders by the anesthesiologists for implementation in the PACU will be entered via CPOE.

ii. These orders should be discontinued by the receiving unit or when time indicated by the Anesthesiologist.

b. Ambulatory Surgery Patients Not Admitted to Hospital:

These patients will continue to be managed via CPOE until the time of their discharge from the Ambulatory Surgery Unit.

c. All Other Patients:

When the patient is admitted to PACU, all orders will be entered via CPOE by the ordering provider.

F. DISCHARGES:

1. When the ordering provider decides to discharge a patient from a unit, he/she will order a *Discharge Patient - Physician order.* This is intended to communicate the plan to the nursing staff.

2. Once the nurse has completed the discharge process and the patient is physically leaving the unit, the patient will be removed from the system by the Unit Secretary or RN after all nursing documentation is completed.

IV. Nursing Responsibilities:

A. ORDER ENTRY:

1. Assisting with Orders:

a. It will be the responsibility of the nursing staff to enter the following orders in the facility electronic order entry system:

i. Telephone orders from ordering providers. These orders must be entered into the facility electronic order entry system with a communication type of “Telephone Order”.

b. As soon as it is known of the facility electronic order entry system downtime, written orders will be started until the facility electronic system is back up.

c. Orders entered by nurses per protocol and/or standing orders, for example, alerts, emergencies, and patient care orders.

2. Height and Weight & Allergies:

a. The RN or Unit Secretary will enter the patient’s height in centimeters (cm) and weight in kilograms (kg).

b. RNs are primarily responsible for entering allergies at hospital admission based on the admission assessment. Allergies can be reviewed/updated by the responsible RNs and ordering provider.

3. Medication Administration Times:

Nursing must call pharmacy and change the ordered medication administration times to a schedule that fits the patient’s current medication regime.

4. Specimen Collection and lab tests:

For the purpose of more appropriate scheduling of specimen collection (i.e., to combine with existing scheduled test or to enable collection at

a time when the patient is available), Nursing can cancel and reorder lab tests to be collected. To ensure correct timing of specimen collection for Peak and Trough levels, the same type of rescheduling activities are allowed.

5. Nursing Alerts:

Nursing may enter the following protocols: Skin Care Protocol, Nutrition Referral, and other orders that enhance patient care and do not require a physician's order (i.e. assist with meals).

6. Clarification of Orders:

If any orders are unclear or need clarification by nursing, the ordering provider who entered the order will be contacted.

B. REVIEW OF ORDERS:

1. NOR Link:

a. The Nurse will review the NOR link at least once every two hours and at the end of the shift with on-coming shift to see if there are new orders.

b. This will create an electronic record in the facility electronic order entry system indicating that the RN has reviewed and acknowledged the order(s). Orders must be carefully evaluated by both pharmacy and/or nursing for patient safety.

c. The RN must also check the chart rack to assure any written orders on any patient are acted upon and entered as needed within his/her shift.

d. The RN should receive the nursing copy of all new written orders.

2. Communication with Other Departments:

a. Nursing will continue to communicate with the ancillary departments as appropriate, related to STAT orders, scheduling of tests and/or confirmation of orders.

3. Active Order Profile:

a. Nurse is able to review the Patient Reports for open orders. This report will be an updated reference tool that can be printed "on demand" as needed.

b. The most recent Medication Administration Record (MAR) must be printed and placed in the patient's chart when a patient goes to the Operating Room.

C. ADMISSIONS, TRANSFERS AND DISCHARGES:

See: Sections D, E, and F under physician responsibilities.

V. Unit Secretary Responsibilities:

A. ORDER ENTRY:

1. Height and Weight:

The RN or Unit Secretary will enter the patient's height in centimeters (cm) and weight in kilograms (kg).

2. Written Orders:

The Unit Secretary is also responsible for entering any written orders, except medications, received on patients and notifying the nurse that orders have been entered by giving the nurse the yellow copy of the order sheet and placing the chart in the "Orders to be verified" rack.

3. Assisting with order entry:

Unit Secretary shall be available to assist any of the ordering providers with order entry questions.

4. Transfer patients, and Discharge patients from system (ADT):

The unit secretary will be responsible for admitting, transferring, and discharging patients utilizing designated facility ADT system when necessary.

Note: In the event that the patient is inadvertently discharged from the system and all orders are removed from the facility electronic order entry system, the Unit Secretary/RN will call the HELP DESK and/or Pharmacy and request the patient's DOWNTIME COPY OF THE

ACTIVE ORDER PROFILE. The Unit Secretary/RN will then re-enter the orders that were removed from the electronic record.

5. Charges:

The Unit Secretary will enter any charges as needed.

B. ADMISSIONS, TRANSFERS AND DISCHARGES:

See: Sections D, E, and F under physician responsibilities.

VI. Reports and Computer Downtime Support:

A. Reports:

Clinical Order Report is available from the facility electronic order entry system if a paper copy of order information is requested by ordering providers, clinical staff or HIM. The report is sorted in sequence reverse chronological order and contains all relevant active order information for the entire patient encounter. This is an 'on-demand' report.

B. Downtime:

1. In case of extended computer system downtime, IT Operations will have a process in place so that the *Rounding Report-NRSG* will be backed-up to the Back Reporting system every hour, for all designated units. If downtime should occur, the unit will call the IT Help Desk to request this back-up report. IT Operations staff will then print the most recent copy of the report and deliver it to the unit.

2. Clinical documentation will follow downtime process per policy #11-6007 and #12-1041.

3. If downtime involves MAK, follow downtime process per policy #13-5106.

4. The nursing and ancillary staff will be responsible for this downtime process and entry of ordering provider written orders, once the system comes back up.

VII. New order request process:

A. Requesting:

1. New order request form will be filled out with the appropriate information and submitted to Department Director.

2. The Director will review and submit with approval signature.

3. Clinical Analyst will begin order building process.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Computerized Physician Order Entry (CPOE)

Descriptive Type: ~~New~~Revised ~~-~~Policy

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Attachments: None

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Effective Date: ~~05/29/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinic Staff, Clinical Staff and Pharmacy Staff

FROM: Administration

SUBJECT: 340B Drug Pricing Program

I. PURPOSE:

To define the processes that allow Tulare Regional Medical Center (TRMC) to purchase pharmaceuticals at discounted prices for its qualified outpatients that is consistent with the Human Resources Services Administration (HRSA) 340B Drug Discount Purchasing Program as defined by the enactment Section 340B of the Public Health Service Act.

II. PERSONNEL:

- Administration
- Pharmacy
- Finance Department
- Information Management

III. REFERENCE AND RELATED DOCUMENTATION

- Section 340B of the Public Health Service Act
- Office of Pharmacy Affairs 340B Drug Pricing Program website, http://www.hrsa.gov/opa/ (accessed September 2013)
- 340B University Glossary of Terms https://docs.340bpvp.com/documents/public/resourcecenter/glossary.pdf (accessed September 2013)

IV. DEFINITIONS:

- 340B Eligible "Covered Entity": The statutory name for facilities and programs eligible to purchase discounted drugs through the Public Health Service's 340B Drug Pricing Program

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Effective Date: 05/29/14

APPROVED:

Medical Executive Comm.: 05/14/14

Board Of Directors: 05/28/14

(13) Ancillary Services
Pharmacy:
340B Drug Pricing Program
13-5112

- Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low income patients. The Medicare and Medicaid programs augment payments to DSH hospitals to compensate for the added financial burden.

- Sole Community Hospital (SCH): A hospital as defined by section 1886(d) (5) (C) (iii) of the Social Security Act that may be eligible to access 340B discounted drugs.

- Critical Access Hospital (CAH): A specially designated, small rural hospital that qualifies for cost-based payments for Medicare services.

- Disproportionate Share Adjustment (DSA): The Medicare disproportionate share adjustment is an additional Medicare payment to hospitals which treat a high percentage of low-income patients. The factors used to calculate this adjustment are the sum of the ratios of Medicare Part A Supplemental Security Income (SSI) patient days to total Medicare patient days, and Medicaid patient days to total patient days in the hospital.

- Medicare Cost Report: Required by CMS, an annual financial report that details all fixed and variable costs expensed to the care of Medicare patients.

- Contracted Pharmacy: An arrangement through which a covered entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications purchased under 340B.

- HRSA: Health Resources and Services Administration of the Department of Health and Human Services.

- GPO Prohibition: Prohibits 340B participating Disproportionate Share Hospitals (DSH), Children's Hospitals (PED), and Free Standing Cancer Hospitals (CAN) from obtaining covered outpatient drugs through group purchasing organizations.

- Wholesale Acquisition Cost (WAC): The price paid by a wholesaler (or direct purchasers) in the United States for drugs purchased from the drug's manufacturer or supplier.

- Orphan Drugs: Drugs designated by the Food and Drug Administration (FDA) as "orphan drugs", drugs used for rare diseases or conditions. The official Orphan Drug list is posted on the OPA website.

- Parent/Child Sites: The primary covered entity is often referred to as the "parent" site. All outpatient services of the covered entity that are not located within the four walls of the parent location (same physical address) must be registered on the HRSA/OPA database as a "child" of the covered entity (Parent).

- Medicaid Carve-out: 340B entities may elect to purchase drugs for Medicaid patients on a non-340B contract. This activity is termed a "Medicaid carve-out." Entities may choose to do this in order to receive fair Medicaid reimbursement (many states reimburse entities that use 340B for Medicaid patients on a cost plus dispensing fee basis, as the dispensing fee is often not high enough to cover costs). Entities must inform OPA whether they are carving in or out.

- **Facility Specific Definitions:**

  - Inpatient status: The hospital determines that patients have an inpatient status according to hospital policy.

  - Outpatient status: The hospital determines that patients have an outpatient status according to hospital policy.

V. OVERVIEW OF 340B DRUG DISCOUNT PURCHASING PROGRAM REQUIREMENTS

A. Covered Entity/Facility Eligibility

Facilities that receive discounted outpatient drug pricing under the 340B Drug Pricing Program include certain hospitals that are public or private non-profit hospitals serving higher percentages of Medicare, Medicaid or other indigent populations. To be eligible the hospital must meet three requirements:

1. The hospital must have a Medicare Disproportionate Share Adjustment Percentage based on their latest Medicare Cost Report as follows:

   - Disproportionate Share Hospitals (DSH) Adjustment Percentage greater than 11.75%

   - Sole Community Hospitals (SCH) require DSH Adjusted Percentage of 8%

   - Critical Access Hospitals (CAH) do not have a Disproportionate Share Adjustment Percentage requirement.

2. The hospital must meet one of the following criteria:

   - Be owned or operated by a unit of State or local government;

   - Be a public or private non-profit corporation which is formally granted governmental powers by a unit of State or local government; or

   - Be a private non-profit hospital which has a contract with a State or local government to provide health care services to low income individuals who

are not entitled to benefits under title XVIII of the Social Security Act or eligible for assistance under the State plan of this title.

3. DSH hospitals, children's hospitals and free-standing cancer hospitals that meet the first two criteria are eligible to participate in the 340B program if they sign a written certification stating that they will not obtain covered outpatient drugs through a group purchasing organization (GPO) or other group purchasing arrangement in compliance with the third criterion. Rural and Critical Access hospitals are not subject to this GPO prohibition.

B. Site of Care

Off-site outpatient facilities of the covered entity (hospital) may purchase and/or provide 340B drugs to its patients, only if the site of care is listed on the HRSA/OPA 340B database. Off-site facilities eligibility is verified by HRSA/OPA as listed as part of the covered entity's most recently filed Medicare Cost Report. The facility must be listed as an integral part of the hospital and included as reimbursable section of the Medicare Cost Report. An eligible clinic/office is considered a "child" of the covered entity ("parent") even if the location is within the same building of a "parent"; they must be registered separately. Outpatient services within the four continuous walls of the covered entity (hospital/parent) do not need to be registered as a child.

C. Patient Eligibility

1. A patient is considered a 340B eligible patient of the covered entity, only if the following conditions are met:

   - The patient is an *outpatient* of the covered entity.
   - The covered entity has established a relationship with the individual, which includes maintaining records of the individual's health care at the covered entity (parent) or a HRSA/OPA registered site of care (child).
   - The individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the individual's care remains with the covered entity.

Note: Employees of the hospital (covered entity) are not automatically 340B eligible patients solely by virtue of their employment status. A medical relationship must extend beyond the dispensing of medications for subsequent self-administration or administration in the home setting.

D. Prescriber Eligibility

Eligible prescribers of 340B drugs are employed by the hospital/covered entity or are under contractual or other arrangement with the hospital/covered entity. The hospital maintains a separate listing for each type of prescriber.

E. Duplicate Discount - Medicaid Carve-in Medicaid Carve-out

A covered entity may choose to carve-in 340B drugs for their Medicaid patients. On the HRSA/OPA database the covered entity would check 'yes' on the Medicaid tab and provide the Office of Pharmacy Affairs (OPA) with their Medicaid provider number, which is then placed in the HRSA Medicaid Exclusion file provided to the State agencies. This prevents the State from taking a duplicate discount with the manufacturer's rebates.

F. GPO Exclusion/Prohibition

Disproportionate Share Hospitals (DSH), Children's Hospitals, and Free Standing Cancer Hospitals (CAN) are prohibited from obtaining 340B covered outpatient drugs through Group Purchasing Organizations (GPO).

G. Orphan Drug Rule

Orphan Drugs as designated by the Food and Drug Administration (FDA) may **not** be purchased by Critical Access Hospitals (CAH), Sole Community Hospitals, Rural Referral Centers (RRC) or Free Standing Cancer Hospitals (CAN) under the 340B Program. Effective October 1, 2013, FDA designated Orphan Drugs may be purchased by these covered entities under the 340B Program for **non**-Orphan Drug status indications. Auditable records must be maintained to show the drug was dispensed for a **non**-Orphan Drug Status indication.

VI. POLICY

A. TRMC participates in the 340B Drug Pricing Program.

B. It is the policy of TRMC to operate the 340B Drug Pricing Program in compliance with guidelines set forth by the Office of Pharmacy Affairs (OPA) of the Health Resources and Services Administration (HRSA); and any accompanying regulations or guidelines including, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient.

C. TRMC is listed correctly as an eligible covered entity with the Office of Pharmacy Affairs (OPA) on the website http://www.hrsa.gov/opa/

D. TRMC's eligible off-site outpatient facilities/clinics and outpatient services outside of the four walls of the hospital are listed correctly as eligible child sites of the covered entity with the Office of Pharmacy Affairs (OPA) on the website http://www.hrsa.gov/opa/. The cost of operating these sites appears on the reimbursable section of the Medicare Cost Report.

E. Contract Pharmacy(ies) of TRMC as stipulated in the *Contract Pharmacy Services Agreement(s)* between the hospital and the contract pharmacy are correctly registered with the Office of Pharmacy Affairs (OPA). See Related Policy: 340B Contract Pharmacy Arrangement, if applicable.

F. 340B medications are purchased for 340B eligible outpatient use only (i.e. a patient is an outpatient at the time the medication is administered/dispensed).

G. The Prime Vendor Program is utilized to increase savings opportunities via the 340B program.

H. The hospital maintains lists of eligible prescribers, eligible outpatient treatment areas and off-site clinics, and registered contract pharmacies.

I. TRMC maintains auditable records demonstrating compliance with the 340B requirement.

VII. PROCEDURE

A. Responsible Parties

1. Authorizing Official

   - Attests to the compliance of the program during the OPA recertification process

2. Contact Official

   - Designated as the hospital's primary contact as listed on the OPA website

3. Director of Pharmacy

   - Acts as an agent of the authorizing official and is responsible for administering the 340B program to optimize appropriate savings and ensure policies and procedures are in place to maintain program compliance.

- Maintains knowledge of policy changes impacting the 340B program including but not limited to, HRSA/OPA rules and Medicaid changes.

- **340B Enrollment, Recertification and Change Requests**

  1. The hospital's authorizing official annually recertifies information listed on the OPA website.

  2. New service areas or clinics/facilities are evaluated to determine if the location is eligible for participation in the 340B Program. If deemed eligible the authorizing official completes the online registration process during the registration window and submits cost report information as required by OPA. New service areas are not eligible to purchase 340B drugs until they are listed on the OPA website.

  3. It is the ongoing responsibility of TRMC to inform OPA of any changes to its information or eligibility. An online change request is submitted as soon as the hospital is aware of the need to make a change to the database entry. If the hospital loses eligibility, it will notify OPA immediately and stop purchasing 340B discounted drugs.

- **340B Drug Utilization**

  1. Medications purchased under the 340B Drug Pricing Program are ONLY utilized for 340B *eligible outpatients,* as defined above, receiving medical care at:

     - TRMC

     - OPA registered child sites (clinics/offices) of TRMC

       - Registered clinics/offices where medications purchased through the 340B account may be used are listed in Attachment A.

     - OPA registered 340B Contract Pharmacy(ies) of TRMC as stipulated in the *Contract Pharmacy Services Agreement(s)* between the hospital and the contract pharmacy. See Related Policy: 340B Contract Pharmacy Arrangement.

- **Purchasing**

  1. As a DSH hospital, purchase of 340B eligible drugs for outpatient use through the group purchasing organization (GPO) or group purchasing arrangement is **prohibited.**

2. As a hospital subject to the GPO prohibition, the hospital does **not** purchase covered outpatient drugs through a GPO for any of its clinics/departments within the four walls of the hospital (same physical address) or any of its registered child site.

3. Off-site outpatient clinics/facilities of the hospital **may** use a GPO account to purchase covered outpatient drugs if those off-site outpatient clinics/facilities meet all of the following criteria:

   - Are located at a different physical address than the hospital;
   - Are **not** registered on the OPA 340B database as participating in the 340B Program;
   - Purchase drugs through a separate pharmacy wholesaler account other than the 340B account; and
   - The hospital maintains records demonstrating that any covered outpatient drugs purchased through the GPO at these sites are not utilized or otherwise transferred to the parent hospital or any outpatient facilities registered on the OPA 340B database.

VIII. Drug Wholesaler Accounts

A. Separate accounts are maintained with the hospital's medication wholesaler. Purchase orders are entered in the wholesaler system under the appropriate account.

1. 340B Account - The 340B account is used for purchasing:

   - 340B medications for eligible outpatient use as defined in this policy.

B. Wholesaler Acquisition Cost (WAC) Account

1. A WAC account is used by facilities that are subject to GPO exclusion/prohibition.
   [Note: The Apexus Prime Vendor Program contracts may be used in place of the WAC acquisition, if applicable.] The account is used for:

   - New drugs or NDC products that are purchased for the first time and will be used in a mixed inpatient outpatient setting.
   - Drug utilization that cannot be attributed to either inpatient or outpatient use.
   - Medicaid carve-out 340B drug utilization.

IX. Inventory Management

A. Physical Inventory Separation

Physical inventory separation is used for:

- 340B medications when the medications are exclusively used in a specific outpatient setting. (These areas are identified as 'Clean' on the Cost Center List). These medications are ordered prospectively via the hospital's 340B account. For example, medications ordered for an outpatient oncology clinic are stored in a separate location from inpatient drugs.

- Inpatient medication purchased strictly for inpatient use may be purchased from the GPO and are purchased on the inpatient account. These medications are stored with the inpatient inventory. (These locations are identified as "Not Eligible" for 340B pricing on the Cost Center List)

- Physical inventory separation may be used in areas where both inpatient and outpatient patients are "mixed" together but a virtual inventory process is generally employed. (These locations are identified as 'Mixed' on the Cost Center List).

B. Virtual Inventory Separation

- Virtual inventory separation is generally used in mixed settings where some patients are inpatient and some patients are outpatient. (These locations are identified as "Mixed" on the Cost Center List).

- Drug utilization in mixed settings is separated into different buckets base on 340B eligibility;

    - Wholesale Acquisition Cost (WAC), 340B or GPO

- Mixed setting 340B drug utilization is purchased retrospectively.

C. Virtual 340B Inventory Management Systems (Manual Spreadsheet)

- Each month the pharmacy generates/receives outpatient and inpatient utilization reports that reflect: drug identifiers, drug description and quantity dispensed to outpatients and inpatients. This report includes data from each treatment area in the hospital where 340B or GPO drugs are utilized. Patient, treatment area and provider information are used to determine the appropriate account for ordering.

- The outpatient utilization report is used to determine the quantity of product for purchase on the 340B (outpatient) wholesaler account.

- The inpatient utilization report is used to determine the quantity of product for purchase on the GPO wholesaler account.

- A virtual inventory is maintained showing drug identifier, drug description, 11 digit-NDC number, quantity accumulated, package unit of measure, and packages eligible for ordering on each account.

- Outpatient utilization is matched to the same 11-digit NDC number for the appropriate 340B product.

- Drug procurement quantities are accumulated based on the utilization reports and converted into wholesaler orderable quantities for each account. In the absence of documentation in either utilization report, drugs are purchased from the WAC account.

- A copy of each month's original outpatient and inpatient charge (utilization) files (including patient ID and date of service) are retained in the pharmacy for auditing purposes.

- Each month, a report of 340B and GPO purchases from the wholesaler accounts are generated. Items that have been purchased on each account are deducted from the total packages on the virtual inventory (manual spreadsheet).

D. Automated Split-ordering/billing Virtual 340B Inventory Management Systems

- TRMC utilizes Sentry Data Systems to manage the process of identifying eligible prescriptions/orders for inpatient GPO purchases and outpatient 340B purchases. The split-billing software determines the eligibility and patient's status; medication dispensed and maintains a virtual drug inventory for each of the purchasing accounts. The software is used to manage the drug inventory in 'mixed use' patient population where both outpatient and inpatient medications are used.

- Split-billing software separates or 'splits' the purchase order (PO) for each item based on eligibility determination of the patient's status, provider, treatment location and 11 digit NDC match. Based on the eligibility determination, the PO is "split" between WAC, 340B eligible drugs, and GPO eligible drugs.

- Split-billing software submits the order back to the wholesaler electronically in separate PO's:

    - WAC Account

    - 340B Account (340B eligible drugs) and

- GPO Account (GPO eligible drugs)

- The separate purchase orders are submitted to the wholesaler.

X. Changes to Wholesaler Drug Ordering Procedures

A. For the purpose of 340B compliance, changes in wholesaler drug ordering procedures are managed using the following guidelines:

1. Long Term Shortages

   a. For situations in which there will be an extensive shortage of a medication (e.g., manufacturer backorder), the following steps occur:

      - The first acquisition of a new NDC# is purchased on the WAC account.

      - The pharmacy information system is updated with the new NDC number.

      - It is assumed that drugs in stock in the pharmacy as of this date will be used on qualified outpatients for the next 30 days.

      - The 340B database is updated 30 days later to allow existing inventory to be used.

2. GPO Contract Rolls

   a. For GPO contract rolls, the following steps occur:

      - Identify the start date of the new contract(s).

      - The pharmacy information system is updated with the new NDC number.

      - It is assumed that drugs in stock in the pharmacy as of this date will be used on qualified outpatients for the next 30 days.

      - The 340B database is updated 30 days later to allow existing inventory to be used.

3. Package Size Changes

   Changes in the manufacturer package sizes result in changes in the number of doses required for reorder. In these instances, a new CDM is assigned to the line item to maintain the integrity of the inventory database.

XI. Billing/Utilization

A. Bundling

1. Based on the current Ambulatory Payment Classification (APC) group payments for a particular service, appropriate billing practices for bundled drugs is determined. The application of bundling charges is consistent throughout the organization. Based on these practices, the hospital determines which drugs may be separately "billable" and therefore, "unbundled" in order to utilize 340B pricing.

   - Drugs that are part of/incident to another service, and payment is not made as direct reimbursement of the drugs, are "bundled" drugs.

   - Drugs that are "bundled" are not 340B eligible drugs and may be purchased on a GPO account.

   - Bundling charges is not used to avoid compliance with GPO prohibition.

B. Third Party Payers

Prescriptions for outpatient medications are priced according to specific price agreements with payers.

C. Medicaid

1. Prescriptions for MEDICAID patients are priced in accordance with state requirements:

   - CARVE IN: The hospital/covered entity uses 340B drugs for Medicaid patients.

     - The hospital confirms that all Medicaid billing numbers and NPIs used by the hospital to bill Medicaid for 340B drugs are listed in Medicaid's Exclusion File Database.

XII. Monitoring and Auditing

A. The following guidelines are used for the purpose of monitoring 340B compliance:

Monthly:

1. Database Crosswalk

   - Randomly select any drugs from the Pharmacy Information System.

- Record the NDC number assigned to each drug product.
- Determine if each NDC number matches the NDC number of the product on the shelf.
- Review accuracy of units of measure for each product.
- Validate that the product is currently mapped accurately in the database crosswalk.

Quarterly:

1. Validation of Eligibility

   - Log onto the Office of Pharmacy Affairs web site to validate participation in the program. http://www.hrsa.gov/opa/introduction.htm.
   - Review the hospital Medicare Cost Report to identify:
     - Changes in classifications of departments and outpatient treatment areas.
     - The DSA% on the Medicare Cost Report remains at 11.75% or higher for DSH; or at or above 8% for SCH.

2. Outpatient Treatment Areas

   - Review the treatment area cost centers and center numbers. This list identifies treatment areas as 'Clean' (outpatients only treated), 'Mixed' (inpatient and outpatients treated) or 'Not Eligible' for 340B pricing.
   - Re-classify clinics as necessary.
   - Classify any new clinics and cost centers. Verify with Information Systems staff that the clinic cost centers are included in the Outpatient Charge Capture Report.

3. PO Generator Facilities

   - Download a 340B purchase history report for a three month period for several drugs that are administered only in outpatient treatment areas. Compare the number of units purchased against the number of units justified by documented charges.
   - Investigate discrepancies that are larger than can be explained by small shifts in on hand inventory.

4. Wholesaler Pricing

   - The availability of the prices are verified by random checks of pricing in the wholesaler database.

5. Compliance Checklists

   - Complete SNHPA's 340B Compliance Checklist. Any significant findings are addressed with a plan of correction and reported to hospital administrator.

   - Complete Automated Inventory Management Audit Plan Check Sheet as defined by the proprietary software.

~~XIII. Attachment A: Listing of TRMC 340B Eligible Medical Clinics~~

- ~~Hillman Health Care Center~~
- ~~Lindsay Health Care Center~~
- ~~Kingsburg Health Care Center~~

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: 340 Drug Pricing Program

Descriptive Type: ~~New~~Revised Policy

Document Number: 13-5112

Attachments: None

Author: ~~Mimi Clayton~~Stefanie Aflague, Pharmacy Director

Typist: Julie Gresham

Creation Date: 04/29/14

Revision Date: 04/23/018

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~05/05/14~~	
MEC	~~05/14/14~~	
Board of Directors	~~05/28/14~~	

Effective Date: ~~05/29/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Clinical Services, Medical Imaging

FROM: Administration

SUBJECT: Certification Requirements for Use of Fluoroscopy Units and Radiographic Units

In accordance with the State Radiology Technology Act and personal correspondence from the Senior Health Physicist, Radiologist Health Branch, State of California, the following regulations are now in effect as law:

> "A non-radiologist physician shall posses an appropriate Fluoroscopy or X-Ray Supervisor and Operator Certificate issued by the State Department of Health Services Radiologic Health Branch if the physician personally activates a fluoroscope (either a conventional unit or a "C" arm with or without electronic radiography mode) or if the physician supervises the use of a fluoroscopy i.e. has direct control over the patient's radiation exposure.
>
> Thus, if an orthopedic surgeon, cardiologist, gastroenterologist, or other physician uses a fluoroscope, that physician must possess a valid Fluoroscopy Certificate. An appropriate "certified Fluoroscopy Supervisor may permit a qualified radiologic technologist to assist by allowing the technologist to activate and manipulate the fluoroscope."

Therefore, effective immediately, no non-radiologist physician may use a fluoroscope or x-ray unless that physician holds a valid Fluoroscopy or X-Ray Supervisor and Operator Certificate issued by the California Department of Health and Human Services, Radiologic Branch, and all non-radiologist physicians must provide the hospital with a copy of their certificate.

A non-radiologist physician shall be solely responsible for obtaining the appropriate certification from the California Department of Health, Radiologic, and Health Branch. To obtain the appropriate Fluoroscopy or X-Ray Supervisor and Operator Certificate, all physicians except diplomats of the American Board of Radiology shall pass a fluoroscopy examination administered by the Department of Health Services or their designee. All physicians shall submit an application to the Department of Health Services and pay an application fee. Duplicate original certificates are accepted. Duplicate certificates may be obtained from the Department by written request and a payment of a nominal fee for each duplicate copy. The Department of Health Services considers it the physician's responsibility and obligation to obtain pertinent information on, and have a thorough understanding of the benefits and risks involved in the use of X-rays on human beings. They consider the possession of an appropriate Fluoroscopy or X-Ray Supervisor and Operator Certificate as defacto evidence of such knowledge.

Board of Directors: ~~01/14/09~~
Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Certification Requirements for Use of Fluoroscopy Units and Radiographic Units

Descriptive Type: Revised

Document Number: 13-7002

Attachments: None

Author: Duane Iwamura

Typist: Hillary Keith

Creation Date: 2/4/08

Revision Date: 1/17/18

Prev. Dist. Date: 1/27/05

Committee Review and Approval:	Approval Date:	Comments:
Radiation Safety Committee	~~11/25/08~~	
MEC	~~12/10/08~~	
Board of Directors	~~01/14/09~~	

Effective Date: ~~01/15/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : Radiology, Nursing, Maintenance, Communications, Purchasing

FROM : Administration

SUBJECT: Receipt of Packages Containing Radioactive Materials When Radiology and Nuclear Medicine Personnel Are Not In the Department

Tulare Regional Medical Center operates a Nuclear Medicine service, which routinely receives deliveries of radioactive materials for use within the department. It is recognized that these materials may be delivered at times that the Nuclear Medicine Department is not staffed.

To clarify the established procedure for receipt and handling of such materials in this event, the following policy procedure should be followed:

1. Any packages containing radioactive material that arrive shall be accepted and signed for by one of the following: MI Technologist on duty, Nursing Supervisor or designee, or Security Officer.

2. The MI Technologist on duty, Nursing Supervisor, or Security Officer will take any package containing radioactive material directly to the Nuclear Medicine imaging room.

3. The MI Technologist on duty, Nursing Supervisor or Security Officer will unlock the door to the Nuclear Medicine imaging room. The same individual will sign the packing slip that accompanies the package if one is available; place the package and a copy of the signed packing slip on the floor immediately to the right inside the door. The door should then be locked upon leaving.

If the package appears to be wet or damaged, the individual handling the package should avoid direct contact with the wet substance and immediately notify the Radiation Safety Officer or the Nuclear Medicine Technologist on-call. An effort should be made to limit unnecessary handling of the package. The parcel carrier should be asked to remain at the hospital until it can be confirmed that neither he nor the delivery vehicle has been contaminated with any radioactive material.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Are Not In the Department

Board of Directors: ~~03/25/09~~ 13-7003

Descriptive Name: Receipt of Packages Containing Radioactive Materials When Radiology and Nuclear Medicine Personnel Are Not In the Department

Descriptive Type: Revised

Document Number: 13-7003

Attachments: None

Author: Duane Iwamura

Typist: Hillary Keith

Creation Date: 02/04/08

Revised Date: 01/17/18

Prev. Dist. Date: 01/27/05

Committee Review and Approval:	Approval Date:	Comments:
Radiation Safety Committee	~~11/25/08~~	
MEC	~~03/11/09~~	
Board of Directors	~~03/25/09~~	

Effective Date: ~~03/26/09~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Imaging, Medical Records, Emergency Room, and Medical Staff

FROM: Administration

SUBJECT: Release of X-ray Films

Tulare Regional Medical Center patient medical records, including x-ray films, are the property of Tulare Regional Medical Center. (See California Administrative Code, Title 22, Section 70751, (b), (c).) Patient records are maintained for the benefit of patients, the medical staff, and the hospital. Tulare Regional Medical Center is responsible for safeguarding all patient records, including x-ray films, and the informational content of those records against loss, defacement, tampering and unauthorized use.

Tulare Regional Medical Center shall endeavor to ensure the above. To this end, **original** medical imaging examination films or CD's containing such images may be disclosed **only** to Tulare Regional Medical Center medical staff members and physicians within Tulare County with the exception of original mammograms. Only through written request and authorization from the patient will Tulare Regional Medical Center allow original films to be sent outside the county or to non-medical staff members or facilities.

It is imperative that original films be returned in a timely fashion, usually within 30 business days of receipt. Images released on CD's do not need to be returned.

Copies of medical imaging examination films may be obtained by patients and medical staff members to the extent authorized by state and federal law.

The requestor or third party payor shall be charged ten dollars ($10.00) per sheet of copy film. Charges do not exceed actual cost.

Copies of x-rays, CD's or tracings may be sent to another health care provider, within 15 days after receipt of a valid authorization for release of such records, signed by the patient or the patient's legal representative. All requests must specify the name and address of the health care provider to whom the records are to be delivered.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~05/26/11~~

APPROVED:

Medical Executive Comm.: ~~05/11/11~~

Board Of Directors: ~~05/25/11~~

(13) Ancillary Services
Medical Imaging:
Release of X-ray Films
13-7005

Descriptive Name: Release of X-ray Films

Descriptive Type: Revised

Document Number: 13-7005

Attachments: None

Author: Duane Iwamura

Typist: Gillian Busch

Creation Date: 07/15/10

Revision Date: 01/17/18

Prev. Dist. Date: 02/01/07

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~05/11/11~~	
Board of Directors	~~05/25/11~~	

Effective Date: ~~05/26/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Imaging, Clinical Services and Medical Staff

FROM: Administration

SUBJECT: Obtaining Neonatal X-rays

I. POLICY: Medical Imaging Services will be provided in the Intermediate Care Nursery (ICN) in accordance with Title 22 and CCS guidelines.

II. PURPOSE: Timely and accurate medical imaging will be performed as ordered on preterm and term neonates.

III. PROCEDURE:

A. When a Chest, Abdominal, or other portable X-ray is ordered by a physician, every effort will be made to maintain optimum condition of the newborn with minimum handling and under a warming source when necessary.
B. Nursing staff may assist with the positioning of fragile premature infants as they feel is required.

C. An infant's oxygen supply will not be disrupted. Monitor leads may be removed at the R.N.'s discretion.

D. A minimal number of X-rays are to be taken. If the physician is present, the image should be immediately available to the Nursery through PACS for viewing before repeat films are taken.

E. A film that is not acceptable may be repeated one (1) additional time. Additional repeat X-rays can only be taken with an order by the attending physician.
F. Medical Imaging services and consultation necessary to the level of care provided shall be available on a 24 hour basis.

IV. DOCUMENTATION: Nursing staff shall document time, type and tolerance of x-ray testing performed in the neonates chart. Documentation shall also be done when notifying a physician of the result.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

Effective Date: ~~09/25/14~~ (13) Ancillary
Medical Imaging:
Obtaining Neonatal X-rays
13-7010

APPROVED:

Medical Executive Comm.: ~~09/10/14~~

Board Of Directors: ~~09/24/14~~

This guideline replaces and supersedes all policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Obtaining Neonatal X-rays

Descriptive Type: Revised

Document Number: 13-7010

Attachments: None

Author: Patti McCowan

Typist: Melissa Arend

Creation Date: 11/20/08

Revision Date: ~~08/14/14~~

Prev. Dist. Date: 01/27/11

Committee Review and Approval:	Approval Date:	Comments:
Pediatrics Committee	~~08/27/14~~	
MEC	~~09/10/14~~	
Board of Directors	~~09/24/14~~	

Effective Date: ~~09/25/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Radiation Oncology Services Policy

I. INTRODUCTION:

The Radiation Oncology Services at Tulare Regional Medical Center (TRMC) are designed to provide optimal care for the brachytherapy client while protecting the client, visitors and staff from all unnecessary radiation exposure/hazard by adherence to the requirements of appropriate licensing agencies and governing bodies.

II. OBJECTIVES:

A. To establish a framework for the Radiation Oncology Services to meet or exceed the radiation safety requirements established by the California Department of Public Health (Radiologic Health Branch) and to ensure compliance of all regulations pertinent to mandated licensure and State accreditation.

B. To provide a medium for recording and conveying regulations of TRMC and the Radiation Oncology Services.

C. To assure effective management, safety, proper performance of equipment, effective communication and quality control in the Radiation Oncology Service.

D. To protect the environment from unnecessary radiation exposure/hazards.

E. The organization can expect clinical personnel to be capable of identifying work-related sources of radiation and to be familiar with the monitoring of personal exposure to radiation.

III. REGULATIONS, STANDARDS AND POLICIES:

A. Sources of Regulations, Standards, and Policies:

This policy is designed to meet the requirements of the following documents:
California Code of Regulations,
Title 17, Public Health
Thompson West
50 California St., 19th Floor
San Francisco, CA 94111

(800) 888-3600

Guide for the Preparation of applications for Medical programs, Document RH 2010
State of California
Department of Public Health Radiologic Health Branch
1500 Capitol Ave.
P.O. Box 997414
Sacramento, CA 5814-7414
(916) 440-7697

Accreditation manual for Hospitals
The Joint Commission (TJC)

Well-Established Medical Uses, document RH 2010 R
State of California
Department of Public Health Services

B. LICENSE:

1. LICENSE NUMBER 2784-54

2. POSSESSION LIMITS:

Cesium	137 – 575 mCi in 14 sources not over 63 mCi each
Iodine	125 – 1 Ci in seeds not to exceed 1.0 mCi/seed
Iridium	192 – 100 mCi in seeds not to exceed 3.0 mCi/seed
Strontium	90 – 125 mCi in one source
Palladium	103 – 1 Ci in Seeds not to exceed 1.8 mCi/seed

C. LOCATION:

The above materials are to be used only at 869 Cherry Street, Tulare, California

Dosimeters to monitor exposure are stored in the first floor Clinical Director's office (see section D.17 for use).

D. AUTHORIZED PERSONNEL:

1. For authorized personnel and specific uses. (See license, item 1)

E. GENERAL REQUIREMENTS:

1. RADIATION SAFETY COMMITTEE (RSC):

a. The Radiation Safety Committee shall consist of at least a Diagnostic Radiologist, a Radiation Oncologist, two (2) additional medical staff members, the Director of Medical Imaging or his designee, a person representing Nuclear Medicine or his designee, a person representing

Nursing and Administration, and additional non-voting members including the Oncology Nurse. The RSO is the Committee Chairman. (Title 17, 30195)

2. RADIATION SAFETY OFFICER (RSO):

a. Designated Radiologist, M.D., also a member of RSC (Title 17, 30195)

3. RADIATION ONCOLOGY SERVICES (TJC 1.4 & 1.5):

a. Therapeutic nuclear medical services not available at TRMC can be obtained by referral to outside services.

4. ANNUAL REVIEW (TJC 2.1):

a. Policies and procedures are reviewed annually by a medical radiation physicist.

5. MONITORING PERFORMANCE (TJC 2.2.4.):

a. A qualified physician, a qualified medical radiation physicist or other qualified person must:

1. Monitor performance evaluations of treatment equipment at least monthly.

2. Monitor each patient for the prescribed dose (s) distribution to an acceptable degree of accuracy and precision, and

3. Monitor therapy machines, radiation sources, and simulators for proper working order.

6. RECORDS (Title 17, 30293):

a. TRMC shall maintain accurate and complete records as follows:

1. Records of all required surveys and tests.

2. Records of all calibrations.

3. Records of all receipt, transfer and disposal of all sources of radiation.

4. Records of all personnel monitoring exposure records.

5. Results of medical examination and bio-assays resulting from the policies and procedures of D.5.

6. Authenticated reports of radiation oncology procedures are entered into the patient's medical record.

7. REPORTS TO STATE:

a. Notifications by TRMC to the California Department of Public Health, 1500 Capitol Ave., Sacramento, CA 95814, are required as follows:

1. Theft or loss of radioactive material as soon as loss is discovered. (Title 17, 30322)

2. Report of misadministration of radioactive material as in D.9. (Title 17, 30322)

3. Report of excessive exposure in writing within thirty (30) days. (Title 17, 30295); (Reports of Overexposures and Excessive Levels and Concentrations, Title 17, 30297).

b. In addition to any notification required by Section 30295, each user shall make a report in writing within 30 days to the California Department of Public Health, 1500 Capitol Ave., Sacramento, California 95814, or other official agency specifically designated by the Department, of:

1. Each exposure of an individual to radiation or concentrations of radioactive material in excess of any applicable limit as stated on the license issued by the Department;

2. Any incident for which notification is required by section 30295; and

3. Levels of radiation or concentrations of radioactive material, whether or not involving excessive exposure of any individual, in an uncontrolled area in excess of 10 times any applicable limit as stated on the license issued by the Department.

4. Each report required under Section 30297 (a) shall describe the extent of exposure of individuals to radiation or to radioactive material; levels of radiation and concentrations of radioactive material involved; the cause of such exposures, levels, and concentrations; and corrective steps taken or planned to assure against a recurrence. Also, each such report shall include, in a separate part of the report, for each individual exposed the name, social security number, and date of birth; and an estimate of the individual's exposure.

5. An overexposure of a film badge dosimeter or other type dosimeter assigned to an individual is considered presumptive evidence of exposure to the individual, and the user shall

advise the department of such exposure as required by subsections (a) and (b) of this section.

6. Where presumptive evidence of overexposure filed pursuant to Section 30295 (c) or 30297 (c) is rebutted after investigation by the user, the user shall advise the department of the results of such investigation within 30 days. After receiving such advice, the department shall conduct its own investigation and shall render a final decision as to presumptive dose assignment in the matter and shall notify the user of its decision within a reasonable time thereafter.

c. Immediate notification of incidents by phone followed by letter is required for the following (Title 17, 30295):

1. Immediate Notification. Each user shall report promptly by telephone and confirm promptly be letter to the California Department of Public Health, 1500 Capitol Ave., Sacramento, California 95814, or other official agency specifically designated by the Department, any incident involving any source of radiation subject to this regulation possessed by him and which may have caused or which threatens to cause:

i. a dose to the whole body of any individual of 25 rems or more; a dose to the skin of the whole body of any individual of 160 rems or more; or a dose to the feet, ankles, hands, or forearms of any individual of 375 rems or more; or

ii. the release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 5,000 times the limits specified for such materials in Section 30355, Appendix A, Table II; or

iii. a loss of one working week or more of the operation of any facilities affected; or

iv. damage to property in excess of $100,000.

2. Twenty-four Hour Notification. Each user shall, within 24 hours, notify the California Department of Public Health, 1500 Capitol Ave., Sacramento, California 95814, or other official agency specifically designated by the Department, by telephone and prompt confirming letter of any incident involving any source of radiation subject to this regulation possessed by him or her and which may have caused or which threatens to cause:

i. a dose to the whole body of any individual of 5 rems or more; a dose to the skin of the whole body of any

individual of 30 rems or more; or a dose to the feet, ankles, hands, or forearms of 75 rems or more; or

ii. the release of radioactive material in concentrations which, if averaged over a period of 24 hours, would exceed 500 times the limits specified for such materials in Section 30355, Appendix A, Table II; or

iii. a loss of one day or more of the operation of any facilities affected; or

iii. damage to property in excess of $1,000.

iv. An overexposure of a film badge dosimeter or other type dosimeter assigned to an individual is considered presumptive evidence of exposure to the individual, and the user shall advise the department of such exposure as required by subsections (a) and (b) of this section.

8. REPORTS TO INDIVIDUAL: Provide reports to any individual of his or her radiation exposure data. (See details in Title 17, 30280).

a. Each user shall:

1. Provide reports to any individual of his radiation exposure data. (See details in Title 17, 30280).

2. Provide reports to any individual of his radiation exposure data and the results of any measurements, analyses, and calculations of radioactive material deposited or retained in the body of that individual as specified in this section. The information reported shall include data and results obtained pursuant to Department regulations, orders, or license conditions, as shown in records maintained by the user pursuant to Department regulations. Each notification and report shall: be in writing; include appropriate identifying data such as the name of the user, the name of the individual, the individual's Social Security number, include the individual's exposure information; and contain the following statement:

"Note: This report is furnished to you under the provision of the California Department of Public Health Regulations: Standards of Protection Against Radiation. You should preserve this report for future reference."

b. These reports shall be provided as follows:

1. At the request of any individual, each user shall advise such individual annually of his exposure to radiation or radioactive

material as shown in records maintained by the licensee or registrant pursuant to Title 17, Section 30293 (a) (3) including the results of any calculations of any calculations and analyses of radioactive material deposited in the body of the individual.

2. At the request of an individual formerly engaged in work controlled by the user. The user shall furnish to the individual a report of his exposure to radiation or radioactive material. Such report shall be furnished within 30 days from the time the request is made, or within 30 days after the exposure of the individual has been determined by the user, whichever is later, shall cover, within the period of time specified in the request, each calendar quarter in which the individual's activities involved exposure to radiation from radioactive materials licensed by, or radiation machines registered with the Department; and shall include the dates and locations of work under the license or registration in which the individual participated during this period.

3. When a user is required pursuant to Title 17, Section 30297 (a) (1) to Report the Department any exposure of an individual to radiation or radioactive material, the user shall also provide the individual a report on his exposure data included therein. Such reports shall be transmitted at a time not later than the transmittal to the Department.

4. At the request of an individual who is terminating employment or assignment to work involving radiation exposure in the user's facility in a given calendar quarter, the user shall furnish to the individual a written report of the individual's exposure to radiation or radioactive material received during that specifically identified calendar quarter. Such report shall contain an estimate of exposures if the final reports are not available at the time of termination. Estimated exposures shall be clearly indicated as such.

9. **NOTICES:** The following notices are required by Title 17, 30280 as indicated below:

a. Conspicuously post a current copy or RH 2364, "Notice to Employees."

b. Conspicuously post a copy of the regulations of Title 17 or a notice of where it can be found.

10. **ORIENTATION AND EDUCATION PROGRAM** (Title 17, 30280, JCAHO, 2.2.10, and Document RH 2010 p. 20):

a. An orientation and education program is planned and carried out for all Personnel whose duties include caring for the implant patients or their surroundings, including technical, clerical, nursing, custodial and security. Such an in-service educational program will be provided before assuming duties and will include an annual refresher on the following topics as appropriate to duties:

1. Area where radioactive material is used or stored.

2. Potential hazards associated with radioactive material.

3. Radioactive safety procedures appropriate to their respective duties.

4. Pertinent California regulations.

5. Rules and regulations of the licensee.

6. Pertinent terms of the license.

7. Obligation to report unsafe conditions.

8. Appropriate response to emergencies or unsafe conditions.

9. Their right to be informed of their radiation exposure and bioassay results.

10. Locations where licensee has posted or made available notices, copies or pertinent regulations, and copies of pertinent licenses and licensee conditions.

11. Prenatal radiation exposure.

12. The ALARA program.

11. VERIFY (DOCUMENTED) THAT PERSONNEL WILL BE PROPERLY INSTRUCTED (Document RH 2010 p. 21):

a. Before assuming duties with or in the vicinity of radioactive materials.

b. During annual refresher training.

c. Whenever there is a significant change in duties, regulations, or terms of the license.

12. RADIATION ONCOLOGY SAFETY POLICIES/PROCEDURES:

a. ALARA (Title 17, 30253 and Document RH 2010 p.12):

1. It is the policy of Tulare Regional Medical Center that radiation exposure to both patients and personnel shall meet the State goal of "As Low As Reasonably Achievable."

13. DOSE LIMITS:

a. Occupational: Dose limits observed at TRMC are as indicated in Title 17, 30265:

1. Except as provided in Section 30265 (b), no user shall possess sources of radiation in such a manner as to cause (1) any individual 18 years of age or over to receive an occupational dose in excess of the limits specified in the following table, or (2) any individual under 18 years of age to receive an occupational dose in excess of 10% of the limits specified in the following table:

	Rems per year
Whole body	5.0
Extremities	50.0
Organ doses, stochastic effects	5.0
Organ doses, non-stochastic effects	50.0
Lens of the eye	15.0

2. The limit for embryo/fetus during the entire gestation period is to be 0.5 rem delivered at a fairly uniform rate. This limit applies to any woman who has declared the pregnancy to the hospital.

b. Occupational: Determination of prior dose: Title 17, 30265.1:

1. Each user shall require any individual, prior to first entry into any controlled area maintained by the user where internal dose assessment or personnel monitoring is required pursuant to Title 17, Section 30266 and 30276, to disclose in a signed statement, either:

i. that the individual had no prior occupational radiation exposure during the current calendar quarter, or

ii. the nature and amount of any occupational radiation exposure which the individual may have received during that current calendar quarter.

c. In determining an individual's accumulated Occupational dose for purpose of Section 30265 (b) (2), the user shall make a reasonable effort to obtain reports of the individual's previously accumulated occupational dose. For each period for which the user obtains such reports, the dose shown in the reports of the individual's occupational

dose for a previous complete calendar quarter, it shall be assumed that the individual has received an occupational dose to the whole body of 3.75 rems for each calendar quarter prior to 1961. The dose may be noted as zero for any periods for which it can be clearly demonstrated that the individual was not occupationally exposed to radiation.

d. If the calculation of an individual's accumulated occupational dose for all periods prior to January 1, 1961, yields a result higher than the applicable accumulated dose value for the individual as of that date, as Specified in Section 30265 (b) (3), the excess may be disregarded.

e. The user shall retain and preserve records used in determining the individual's accumulated occupational dose.

f. Uncontrolled areas: dose limits observed at TRMC are as indicated in Title 17, 30268; Permissible Levels of radiation in Uncontrolled Areas:

1. No user shall possess sources of radiation in such a manner as to create in any uncontrolled area, from such sources, radiation levels which could cause any individual to receive a dose to the whole body in excess of:

i. two millirems in any one hour, or

ii. rem in any one year.

14. SURVEYS AND TESTS (Title 17, 30275):

a. Each user shall make or cause to be made such surveys as are necessary for compliance with all provisions of this regulation.

b. Upon instruction from the Department or other official agency specifically designated by the department, each user shall perform or cause to have performed, and shall permit the Department or said agency to perform, such reasonable tests as the department or said agency deems necessary for the protection of life, health, or property, including, but not limited to, tests of:

1. Sources of radiation.

2. Facilities wherein sources of radiation are used or stored.

3. Radiation detection and monitoring instruments.

4. Other equipment and devices used in connection with utilization or storage of sources of radiation.

c. Each sealed source other than sources listed below, shall be tested for contamination prior to initial use and for leakage at least every six months:

1. Sources containing radioactive material with half-life of 30 days or less.

2. Sources of beta-and/or gamma-emitting radioactive material with an activity of 100 microcuries or less. In the absence of a certificate from a transferor indicating that a test has been made prior to the transfer, the sealed source shall not be put into use until tested. If there is reason to suspect that a source might have been damaged, it shall be tested for leakage before further use. Contamination and leak tests shall be capable of determining the presence of 0.005 microcuries of removable contamination. When any contamination or leak test reveals the presence of 0.005 microcuries or more of removable contamination the user shall immediately withdraw the source from us and shall cause it to be decontaminated and repaired or to be disposed of in accordance with applicable provisions of Group 2 of this subchapter. Two copies of a report shall be filed, within 5 days of the test, with the Department or other official agency specifically designated by the Department, describing the source involved, the test results, and the corrective action taken.

3. The test sample shall be taken from the surface of the source, or source holder, or from the surface of the device in which the source is stored or mounted and on which one might expect contamination to accumulate. Where sealed sources are permanently mounted in devices or equipment, alternate tests for contamination and leakage may be approved by the Department.

4. Tests for contamination and leakage, decontamination, and repair of scaled sources shall be performed only by persons specifically authorized by the Department to do so in accordance with provisions of Group 2 of this subchapter.

5. Records of leak tests shall be maintained as specified in Section 30293.

15. PERSONNEL MONITORING; TRMC complies with the following requirement form Title 17, 30276:

a. Each user shall supply appropriate personnel monitoring equipment to, and shall require the use of such equipment by:

1. Each individual, 18 years of age or over, who enters a controlled area under such circumstances that this individual is likely to receive in any calendar quarter a dose exceeding 300 millirems to the whole body; or 5 rems to the hands and forearms, or feet and ankles; or 2 rems to the skin of the whole body.

2. Each individual under 18 years of age who enters a controlled area under such circumstances that this individual is likely to receive in any calendar quarter a dose exceeding 60 millirems to the whole body; or 900 millirems to the hands and forearms or feet and ankles; or 400 millirems to the skin of the whole body.

3. Each individual who enters a high radiation area.

b. All personnel dosimeters (except for direct and indirect reading pocket ionization chambers and those dosimeters used to measure the dose to hands and forearms, feet, and ankles) that require processing to determine the radiation dose and that are utilized by licensees to comply with paragraph (a) of this section, or with conditions specified in a licensee's license shall be processed and evaluated by a dosimetry processor.

16. BIO-ASSAYS AND MEDICAL REVIEW; TRMC has in place the provisions to comply with the requirements of Title 17, 30277:

a. Each user shall make provision for a regular bio-assay program where indicated by and appropriate to the nature of potential exposure.

b. In cases of known or suspected exposure exceeding permissible values, the department may require any user to provide for medical examination and where indicated, treatment, by a qualified physician acceptable to the department.

17. CAUTION SIGNS AND LABLES (Title 17, 30278):

a. The conventional three-bladed symbol and the words, "CAUTION, HIGH RADIATION AREA," are required on the patient room door whenever sources are used such that the radiation level can reach 100 mR/hr, otherwise there will be posted the same symbol and the sign "CAUTION, RADIATION AREA."

18. SECURITY FOR HIGH RADIATION AREA (Title 17, 30279):

a. In case a HIGH RADIATION condition exists (100 mR/hr or more), the patient room must be secured except during periods when access to the room is required, with positive control over each individual

entry. This will be done in such a way that no one can be prevented from exiting the room.

19. SAFE HANDLING OF RADIOACTIVE MATERIALS (Document RH 2010 Appendix I):

a. The following precautions should be observed when handling sealed sources of radioactive materials:

1. Wear personnel monitoring device

2. Transport radioactive materials in shielded container

20. RECORD AND REPORTS OF MISADMINISTRATION (Title 17, 30322):

a. When a misadministration involves a therapy procedure, the licensee shall notify the Department. The licensee shall also notify the referring physician of the affected patient and the patient or the responsible relative or guardian, unless the referring physician agrees to inform the patient or believes based on medical judgment that telling the patient or the patient's responsible relative or guardian would be harmful to one or the other, respectively. These notifications shall be made within 24 hours after the licensee discovers the misadministration. If the referring physician, patient, or the patient's responsible relative or guardian cannot be reached within 24 hours, the licensee shall notify the patient or the patient's responsible relative or guardian without first consulting the referring physician; however, the licensee shall not delay medical care of the patient because of this.

b. Within 15 days after the initial therapy misadministration report to the Department, the licensee shall report in writing, to the Department and to the referring physician, and furnish a copy of the report to the patient or the patient's responsible relative or guardian if either was previously notified by the licensee, as required by Subsection 30322 (a) (same as D.9.1 of this report). The written report shall include the licensee's name; the referring physician's name; a brief description of the event; the effect on the patient; the action taken to prevent recurrence; whether the licensee informed the patient or the patient's responsible relative or guardian and if not, why not. The report shall not include the patient's name or other information that could lead to identification of the patient.

c. Each licensee shall retain a record of each misadministration for 10 years. The record shall contain the names of all individuals involved in the event, including the physician, allied health personnel, the patient and the patient's referring physician, the patient's social security number or identification number if one has been assigned, brief description of the event, the effect of the patient, and the action taken, if any, to prevent recurrence.

d. Aside from the notification requirement, nothing in Subsection 30322(a) through (d0, (same as D.9.1-D.9.4 of this document), shall affect any right or duties of licensees and physicians in relation to each other, patients, or responsible relatives or guardian.

21. CARE AND RECORDS OF IMPLANT SOURCE:

a. Implant sources are kept in a locked, secure area.

b. A log must be kept indicating supplier, radionuclide, date of receipt, lot number.

c. A list is to be maintained of the names of persons allowed to handle implant sources in the storage area and in the inventory log.

d. A map is drawn and posted of the storage area including activity and source at each storage point.

e. A use log must be kept providing the number and activity of the sources removed from the storage area, the patient's name or room number, time and date of removal from storage, time and date of return to storage - then immediately count and initial the record. (document RH 2010 Appendix H)

f. The custodian of radioactive materials for the Oncology Department (i.e. Radiation Oncologist), or his specified designate shall assure that patients treated with radioactive implants remain hospitalized until a source count and a radiation survey of the patient confirm that all implants have been removed. (Title 17, 30321-I)

g. If a discrepancy is ever observed between the record and the total number in storage and in use, the RSO is to be immediately notified. (Document RH 2010 Appendix H)

h. When not in use all sealed sources shall be kept in a lead container sufficient to ensure compliance with D.1 and D.2 (Title 17, 30221)

22. ORDERING AND RECEIVING RADIOACTIVE MATERIALS (Document RH 2010 Appendix F):

a. The RSO or a sole designee must authorize each order for radioactive materials and ensure that the requested materials and quantities are authorized by the license and that possession limits are not exceeded.

b. The RSO will establish and maintain a system for ordering and receiving radioactive materials. The system must contain the following:

1. Records that identify the user or department isotope, chemical form, activity, supplier

2. Confirmation of order

c. Receipt of Oncology Radioactive Material by TRMC:

1. The RSO or the RSO's sole designee will prearrange with the supplier and/or carrier of the radioactive material for receipt of the radioactive package(s) during the normal working hours of the TRMC materials Management Department (M-F, 0630-1530).

2. No radioactive package(s) will be accepted during off-duty hours M-F, holidays, or weekends by the Materials Management Department.

3. The Materials Management Department will receive a Radioactive Material Receipt Memo prior to the date of delivery. Sample of memo:

MEMO TO: Materials Management Department

FROM : _____ RSO or sole designee

SUBJECT: Receipt of packages containing radioactive material

A package(s) of radioactive material will arrive between 0630 and 1530 on _____ (DATE.

Upon delivery, Material management shall immediately notify _____ (Name) at _____ (Telephone) for receipt of the radioactive materials.

If the package is wet or appears damaged, immediately contact the Radiation Safety Officer. Ask the carrier to remain at the hospital until it can be determined that neither he nor the delivery vehicle is contaminated.

NAME: _____ TELEPHONE: _____

RADIATION SAFETY OFFICER

RADIOLOGIST ON DUTY

DESIGNATED RADIATION ONCOLOGIST

23. RETURN OF RADIOACTIVE MATERIALS TO THE SUPPLIER:

a. The supplement provision of license number 2784-54 regarding the return of radioactive materials to the supplier will be followed.

b. Following usage and removal of isotopes from the patient(s), the radioisotopes will be immediately packed into the same original container that they came in and they will be sent back by UPS to the vendor on the same day or on the next working day. (There should be no exception to this rule.)

c. Records that identify the isotope, chemical form, activity, and outer package radiation measurement will be maintained by the RSO or his designee.

24. PROCEDURES FOR SAFELY OPENING PACKAGES CONTAINING RADIOACTIVE MATERIAL BY THE RSO SOLE DESIGNEE (Document RH 2010 Appendix G):

a. Put on gloves.

b. Visually inspect packages for any sign of damage (e.g., wetness, crushed). If damage is noted, stop procedure and notify Radiation Safety Officer.

c. Measure exposed rate at one meter from package surface and record. If > 10 mR/hr or twice the Transport Index noted on the package or paper, stop Transport Index noted on the package or paper, stop procedure and notify Radiation Safety Office.

d. Measure surface exposure rate and record. If > 200 mR/hr, stop procedure and notify Radiation Safety Officer.

e. Open the outer package (following manufacturer's directions, if supplied) and remove packing slip. Open inner package to verify contents (compare requisition, packing slip, and label on bottle). Check integrity of final source container. In case of irregular findings, notify the Radiation Safety Officer.

f. If leakage or contamination is suspected, determine the extent of contamination (to enable initiation of safety precautions commensurate with the level of contamination) by wiping the external surface of the final source container with a cotton swab held with forceps; assay and record.

g. Check to ensure that shipment does not exceed possession limits.

h. Monitor the packing material and packages for contamination before discarding.

1. If contaminated (above twice natural background rate), treat as radioactive waste.

2. If not contaminated, obliterate radiation labels before discarding in regular trash.

3. In all wipe sample assays, remove wipe samples to a low-background area and check with a thin window (<7mg/cm2 thickness preferred) GM survey meter or a scintillation probe or liquid scintillation counter, if appropriate. Precautions should be taken to prevent the spread of contamination.

25. THERAPEUTIC USE OF SEALED SOURCES GUIDELINES
(Document RH 2010 Appendix N):

a. There is no need to segregate a prostate brachytherapy patient from the general population. Patients should be outpatient or 23-hour stay.

b. Patients undergoing cervical brachytherapy (Cs-137) will be placed in a private room with toilet facilities. The room will be as far away as reasonably possibly from the nursing station and traffic hallway.

c. The patient's room will be properly posted with Radiation warning signs in accordance with Title 17 Section 30278.

d. "Brief" the patient on safety procedures for confinement to bed, visitor control, and other items consistent with good medical care.

e. Surveys of the patient's room and surrounding areas will be conducted as soon as practical after sources are implanted. Exposure rate measurements will be taken at the patient's bedside, at one meter from the bed, and at the entrance to the room. The Radiation Safety Officer or his designee will then determine how long a person may remain at these positions and will post these times and the exposure rate at one meter from the bed on the patient's chart.

f. "Brief" the nurses on radiation safety precautions, and "supplement" immediately after sources are implanted by completing the form "Nursing Instruction for Patients Treated with Brachytherapy sources" and placing it on the patient's chart. This is particularly important when handling patients undergoing cervical brachytherapy.

g. Only those needed for medical safety, or training should be present during implant procedure.

h. Radiation levels in unrestricted areas shall be maintained less than the limits specified in Title 17 Section 30268m or D.2 of this document.

i. Nurses caring for brachytherapy patients shall be assigned dosimetry devices, which are available in the first floor nursing office. Finger

badges may also be assigned to nurses who must provide extended personal care to the patient.

j. At the conclusion of treatment, a survey shall be performed to ensure that all sources have been removed from the patient and that no sources remain in the patient's room or any other area occupied by the patient. Patient trash and linen containers shall be surveyed and verified to be free of radiation. At the same time, all radiation signs will be removed, and all film and TRMC badges assigned to nurses will be collected.

k. Patients with permanent implants may be released from the hospital if the exposure rate from the patient is less than 2 mR/hr. at one meter.

l. If the exposure rate is between 2 mR/hr. and 5 mR/hr. at one meter, the patient shall be given both oral and written radiation safety instruction prior to discharge.

m. Above 5 mR/hr. at one meter a patient shall not be discharged from the hospital.

26. INSTRUCTIONS / GUIDELINES TO NURSES CARING FOR IMPLANT PATIENTS

a. Special instructions may be noted on the precaution sheet on the patient's chart. Nurses should read these instructions before administering care to the patient. Call the Radiation Oncologist, Radiation Safety Officer or his designee with any questions about the care of these patients in regard to radiation safety precautions.

b. Hospital personnel entering the room must wear a personal radiation dosimeter in order to monitor employee radiation exposure levels.

c. Nurses should spend the minimum time necessary near a patient for routine nursing care. When appropriate, nurses should avoid prolonged care near the patient's pelvic region.

d. Pregnant nurses should not be assigned to the personal care of these patients.

e. Any pregnant visitor or children under the age of 18 should avoid direct contact with the patient, i.e. no hugs or sitting on the patient's lap. Visitors should be cautioned to remain at least one meter from the patient during their visit. There is no limit to the length of a visitor's stay due to radiation exposure.

f. Never touch needles, capsules, or containers holding brachytherapy sources. If a source becomes dislodged, use long forceps and place it in the corner of the room in the shielded container provided; notify

the Radiation Therapist, Radiation Oncologist, Radiation Safety Officer or designee.

g. Surgical dressings and bandages used to cover the area of needle insertion may be changed only by the attending physician or Radiation Oncologist, and shall not be discarded until directed by the physician. Dressings should be kept in a basin until checked for radiation contamination by the Radiation Safety Officer or his designee.

h. Special orders will be written for oral hygiene for patients with oral implants.

i. No special precautions are needed for sputum, urine, vomitus, stool, dishes, instruments, or utensils unless specifically ordered, but these items should be saved for a check with a radiation survey meter to ensure that no sources are inadvertently removed.

j. All linens, urine and trash will be saved until surveyed by nuclear medicine (or appropriate Medical Imaging Staff) at patient discharge.

k. Area will be surveyed after discharge of the patient and before Environmental Services is allowed to clean the area.

l. These patients must remain in bed unless orders to the contrary are in any event, patients shall remain in their assigned area during the treatment period.

27. EMERGENCY PROCEDURES (Document RH 2010 Appendix N):

a. If an implanted source becomes lost, loose, or separated from the patient, or

b. if a patient codes, or

c. If a patient dies, or

d. If a patient requires emergency surgery or transfer to the ICU, immediately notify the Radiation Oncologist, RSO, or his sole designee:

1. RADIATION ONCOLOGIST

2. RADIATION SAFETY OFFICER

3. RADIOLOGIST ON DUTY

28. DOSIMETER PROCEDURE:

a. EQUIPMENT:

1. Direct – Reading Pocket Dosimeter (Gamma and X-Ray)

PRESCRIBED ACTION:	POINTS OF EMPHASIS
A. Obtain Dosimeter kit from first floor nurse manager's office along with dosimeter log. B. Identify dosimeter number C. Identify serial number	A. If the manager's office is locked, security can gain access. B. Document serial number on log sheet
A. Prior to each use, the pocket dosimeter must be zeroed out: 1. Charging contact with cap (screws) 2. Remove cap 3. Place the side opposite viewing port down on charging contact. Adjust the "up scale/down scale", control on the charger, while observing the calibrated reticle, until a zero reading is indicated. Adjust to zero or as close to zero as possible, then release slowly.	A. If not zero, then use charger to zero. If dosimeter is dropped, note serial number so X-ray can check out the dosimeter. Do not leave dosimeter near radiation source or near patient. (it will continue to read radiation, and will not give an accurate indication of employee's exposure.
A. Document the starting dosimeter reading (Should be zero if possible).	A. Document in log.
A. Wear dosimeter at neck of scrub top.	A. Must wear the dosimeter on the upper body in order to obtain the most accurate exposure reading.
A. Document end reading, calculate total exposure.	A. Use post-exposure reading minus the pre- exposure reading to calculate total exposure. Document on exposure log.
A Zero out dosimeter and place in kit. Return to first floor nurse manager's office. The manager will communicate with radiology on any exposures.	A. If the manager's office is locked, security can gain access.

29. DOCUMENTATION:

a. Document the pre-exposure dosimeter reading in log.

b. Document end reading, calculate total exposure.

30. RESOURCE: Instruction Manual, Nuclear Associates, Direct – Reading Pocket Dosimeters.

Questions concerning any aspect of this policy should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies concerning this matter and is effective immediately.

Descriptive Name: Radiation Oncology Services Policy

Descriptive Type: Revised

Document Number: 13-7013

Attachments: None

Author: Duane Iwamura

Typist: Julie Gresham/Gillian Busch

Creation Date: 05/26/10

Revised Date: 04/04/18

Prev. Dist. Date: 06/29/06

Committee Review and Approval:	Approval Date:	Comments:
Radiation Safety Committee	~~11/23/10~~	
MEC	~~01/12/11~~	
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Imaging, Clinical Services, OR, Medical Staff

FROM: Administration

SUBJECT: Removal of the Spacer Cone during use of Mobile Fluoroscopy Equipment

I. Purpose:

To define the appropriate guidelines for the safe operation of the mobile c-arm equipment in regard to spacer cone removal during fluoroscopy in the Operating Room and other hospital venues.

II. Policy:

A. The California Code of Regulations Title 17 mandates that a minimum source-skin distance of 30 cm be maintained at all times during fluoroscopy. The Department grants exemptions from the California Radiation Control Regulations as authorized by law and as long as these exemptions do not result in any undue hazard to health, life, or property.

B. Physicians and fluoroscopy personnel are granted an exemption to remove the spacer cones and operate at source-skin distances of not less than 20 cm for medical purposes in which the cone is contraindicated or compromises the procedure.

III. Procedure:

A. Failure to maintain adequate safety measures may compromise patient safety; therefore, it is imperative that the following guidelines be maintained.

1. In cases where the physician or fluoroscopy personnel determines that the standard use of the spacer cone serves to interfere with the safe and smooth operation of the equipment during a procedure, removal of the spacer cone will be allowed.

2. It has been determined that the use of the spacer cone serves to interfere with the safe and smooth operation of the fluoroscopy equipment during the following procedures:

   a. Operative cholangiogram
   b. Retrograde Urography and other urological procedures (stone removal, ureteral stent placement, etc.)
   c. Pacemaker implantation
   d. Port-a-Cath placement
   e. Prostate and other Brachytherapy procedures
   f. ORIF orthopedic procedures (ie, hip, knee, etc.) and closed reduction of certain joint dislocations

3. Although it is highly recommended that the spacer cone remain in place during all procedures, removal of the spacer cone shall be allowing during the procedures listed above if deemed appropriate by the physician or fluoroscopy personnel. Upon completion of the authorized procedure, the spacer cone shall be reinstalled.

4. All physicians and fluoroscopy personnel shall receive training regarding spacer cone use as well as the restrictions involved. Documentation of such training will be maintained by the Radiation Safety Officer or Designee and will be made available during State inspection.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This guideline replaces and supersedes all policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Removal of the Spacer Cone during use of Mobile Fluoroscopy Equipment

Descriptive Type: Revised

Document Number: 13-7015

Attachments: None

Author: Duane Iwamura

Typist: Julie Gresham/Gillian Busch

Creation Date: 07/14/10

Revision Date: 01/17/18

Prev. Dist. Date: 01/04/07

Committee Review and Approval:	Approval Date:	Comments:
Radiation Safety Committee	~~11/23/10~~	
MEC	~~01/12/11~~	
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Imaging, Clinical Nursing Services, PBX and Medical Staff

FROM: Administration

SUBJECT: STAT After Hour Echocardiography Services

I. PURPOSE:

Define the appropriate guidelines for ordering and obtaining STAT Echocardiogram studies outside of normal business hours.

II. POLICY:

A. Cardiovascular ultrasound services are available on a limited basis during the hours outside of normal business hours. At this time, Tulare Regional Medical Center staffs technologists for emergency procedures up to 5:30 pm weekdays and retains on-call personnel from 0700-1900 hrs on weekends and holidays.

B. In the event that an STAT Echo is required, the following procedure will serve as a guideline in securing the appropriate services.

II. PROCEDURE:

A. The ordering physician (with the exception of the Emergency Department Physician) requesting a STAT or Emergency Echo study (after normal business hours), or the nurse in charge of the patient's care must first contact the Cardiologist on-call in order to validate the appropriateness for the STAT order (Note: Approved indications for a STAT Echo may include evaluation for pericardial effusion, cardiac tampanode, etc.). It is also necessary to confirm that the Cardiologist will either be present during the procedure, or available to provide a STAT interpretation immediately following the examination.

B. After obtaining approval from the Cardiologist, the nursing unit will notify PBX to contact the tech on-duty (duty schedule will be provided to PBX on a monthly basis). PBX will put the tech in contact with the appropriate nurse so that accurate information can be shared concerning the STAT request.

Effective Date: ~~01/27/11~~	(13)	Ancillary Medical Imaging: STAT After Hour Echocardiography Services 13-7016
APPROVED:		
Medical Executive Comm.: ~~01/12/11~~		
Board Of Directors: ~~01/26/11~~		

Nursing will also provide the tech with the name of the Cardiologist that has approved the procedure and inform him or her of any information relative to such (i.e., if the Cardiologist will be present during the study; how to contact the Cardiologist after the exam has been completed, etc.). If PBX is unable to contact the tech on-call, the operator will then attempt to contact an alternate Cardiovascular Ultrasound Tech, until a successful contact is made. If their efforts are unsuccessful, please contact the Director of Medical Imaging for assistance.

C. The tech on-duty will arrive in a timely fashion in response to the STAT request. He or she will perform the procedure accordingly and insure that the exam is available to the Cardiologist for timely interpretation. The technologist will notify the Cardiologist immediately upon completion of the examination.

D. The Cardiologist will review the examination and notify the appropriate individual (i.e., referring physician, RN, etc.) of the results.

E. If the STAT exam has been requested for a patient in the Emergency Department or by the ED Physician, hospital nursing staff may contact the tech directly (via PBX).

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: STAT After Hour Echocardiography Services

Descriptive Type: Revised

Document Number: 13-7016

Attachments: None

Author: Duane Iwamura

Typist: Julie Gresham/Gillian Busch

Creation Date: 07/15/10

Revision Date: 01/17/18

Prev. Dist. Date: 09/27/07

Committee Review and Approval:	Approval Date:	Comments:
MEC	~~01/12/11~~	
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments and All Employees

FROM: Administration

SUBJECT: Radiation Safety Program

I PURPOSE

A. To establish a Radiation Safety Program for all Tulare Local Health Care District Employees who may occasionally encounter radiation sources at work.

B. To provide information and guidelines for all hospital employees who occasionally work around areas that store or use radiation sources.

C. To provide information and establish safety precautions for all hospital employees who occasionally work around patients who are receiving or have received radiation for diagnostic or therapeutic purposes.

D. To meet the objective of reducing the total exposure to radiation by the National Council on Radiation Protection and Measurements to as low as reasonably achievable (ALARA).

E. To satisfy the educational requirements of the: 1994 Accreditation Manual of Hospitals; OSHA; TLHD Safety Policy, "Hazardous Materials and Waste Management Program", the TLHD Oncology Department Policy Manual; and the TLHD Radioactive Material License.

II EXEMPTIONS FROM THIS PROGRAM

A. This program does not meet special educational requirements or training for employees who work daily with patients receiving radiation or with employees who work daily with or around radiation sources or controlled areas.

B. This program does supersede Medical Imaging, Nuclear Medicine or Radiation Oncology procedures for employees having primary responsibility for working with or around radiation sources or controlled areas.

Effective Date: ~~01/27/11~~ (13) Ancillary Services
Medical Imaging:
Radiation Safety Program
13-7017

APPROVED:

Medical Executive Comm.: ~~01/12/11~~

Board Of Directors: ~~01/26/11~~

III PROGRAM EDUCATIONAL DISTRIBUTION

A. Radiation Safety video will be shown at TLHD General Orientation for all hospital employees.

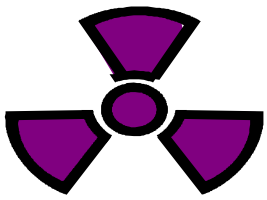
IV RADIATION SAFETY INFORMATION

A. Large exposures to ionizing radiation can cause cancer and genetic defects. To prevent or decrease your exposure to radiation, it is important to know about Radiation Safety.

B. Regulations place strict limits on the amount of radiation that an individual can receive at work. The maximum allowed for most employees each year is about the same as that from a CT Scan. Those who might receive even a quarter of this dose may be issued a film badge and received special work instructions. Regulations have set whole body dose limits for occupational workers (i.e. Radiology, Nuclear Medicine, CT, etc.) at three (3) rads per quarter, and five (5) rads times age over eighteen (18) as a lifetime cumulative.

C. There is (1) one area in the hospital where radiation sources are stored: The Nuclear Medicine Department located in Medical Imaging.

D. The radiation "caution" sign tells you that the room is a controlled area and special precautions are in effect.



The color of the three (3) blade design is in magenta or purple on a yellow background.

E. There are two (2) primary sources of radiation used in diagnosis or therapy that you may occasionally encounter:

1. Mobile X-ray Machines:

   a. Conventional X-ray Machine

   b. Mobile fluoroscope, often called the C-arm

2. Radionuclide's (isotopes, nuclides) used in:

a. Radiation Oncology; implanted (sealed) radionuclide's

b. Nuclear Medicine

V RADIATION SAFETY PRECAUTIONS

A. Three (3) x-ray precautions to take around mobile x-ray machines:

1. Move at least 6 feet away from a portable x-ray unit when it is about to be activated. (Radiation is generated only when making an image.)

2. Wear a lead apron if you need to position a patient during an exposure.

3. Wear a lead apron in a room while a C-arm is in use. The x-ray supervisor (physician) may activate the machine without warning you to move away. Non-essential staff should vacate the room while x-ray is being generated.

B. Four (4) basic radionuclide precautions to take around a patient with an implanted (sealed) radionuclide:

1. Check with a nurse or person in charge before entering a room with a posted radiation caution sign (controlled room).

2. Maintain some extra distance from the patient (approximately 6 feet – distance reduces your exposure).

3. Minimize the amount of time you spend close to the patient. (When an implanted (sealed) radionuclide is removed from the patient, neither the patient nor the room remains radioactive).

4. Tell your Supervisor if you are, or may be pregnant.

C. Two (2) special radiopharmaceutical (liquids) precautions in addition to the four (4) basic radionuclide precautions:

1. Wear gloves when caring for these patients because their body fluids may temporarily contain radioactivity.

2. If indicated, place body fluid containers – contaminated materials in separate, labeled containers. Urine and excreta may be flushed down the toilet.

VI PROCEDURE FOR EMPLOYEE ACCIDENTAL EXPOSURE TO RADIATION SOURCE

A. Notify the current Radiation Safety Officer or designee immediately.

B. Notify Unit Manager or Director

C. Complete incident report

Questions concerning any aspect of this policy should be referred to Administration.

This policy replaces and supersedes all previous policies concerning this matter and is effective immediately.

Descriptive Name: Radiation Safety Program

Descriptive Type: Revised

Document Number: 13-7017

Attachments: None

Author: Duane Iwamura

Typist: Julie Gresham

Creation Date: 09/09/10

Revision Date: 01/17/18

Prev. Dist. Date: 02/23/06

Committee Review and Approval:	Approval Date:	Comments:
Radiation Safety Committee	~~11/23/10~~	
MEC	~~01/12/11~~	
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments: Previously Policy #10-1105

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO:

FROM: Administration

SUBJECT: Transesophageal Echocardiography (TEE)

I. PURPOSE:

To assist the MD in performing a transesophageal Echocardiography (TEE).

II. POLICY:

The CVT will prepare the patient, ready the equipment and assist the MD in the performance of the procedure

III. PROCEDURE:

1. Pre-procedural Patient Preparation:

A. Patient Screening:

1. Performed by the CVT and/or physician.

2. Risk factors and considerations:

- Esophageal disease (dysphagia, varices, strictures or obstructions)
- Bleeding tendencies (hemophilia, taking blood thinner)
- Pulmonic diseases or distress requiring Oxygen at home
- Recent illness
- Prosthetic heart valves: date and type
- Isolation precautions: disease and date tested
- Drug allergies
- Other (i.e. spinal arthritis, radiation to chest, unstable vitals signs, smoke inhalation, pregnancy and denture)

B. Patient Teaching and Documentation:

1. Pre-procedural, in-depth instructions are provided by the

CVT. The physician will explain all risks, benefits and alternatives in detail with the patient, verbalizing understanding.

C. Obtain written consent.

2. Pre-Procedural Preparation of the Patient:

A. The outpatient is taken to the procedure room; the inpatient will remain in his/her patient room, unless other circumstances require the use of the procedure room.

B. The procedure room is prepared before the patient's arrival, i.e. monitoring equipment, medications, suction apparatus, oxygen, gowns, gloves, protective masks and emergency cart available).

C. The patient is to be NPO at least 4 to 6 hours before the TEE. (Medications should be continued, using only minimal sips of water). All feeding tubes or NG tubes must be removed to prevent possible entanglement with the TEE probe.

D. If the procedure is being done on an outpatient basis, the patient must be advised to should be informed not to drive or be exposed to potentially injurious situations for at least 12 to 24 hours after the exam.

E. IV antibiotic prophylaxis is given to patients at risk for endocarditis as recommended by the AHA, for prosthetic heart valves and as the physician deems necessary.

F. The nurse or physician confirms that the patient understands and obtains consent before progressing with the test.

G. Baseline vital signs are obtained and leads are attached to the patient for a continuous ECG monitoring on the ultrasound.

H. IV access is obtained for administration of conscious sedation and to provide a route in the event of an emergency.

3. During the Procedure:

A. Using a protective mask, gown and gloves, the physician will apply the topical anesthetic to the patient's throat to provide a numbing

effect to the patient's gag reflex. The patient is instructed to gargle and spit the anesthetic and suction is used as needed.

B. The patient is then given sedation as ordered by the physician with time allowed to take effect.

C. The patient is position into a comfortable left lateral decubitus position facing the examiner. A pillow or wedge may be used to support the patient's back.

D. Blood pressure, oxygen saturation's, heart rate, respiration's (rate and pattern) and electrocardiogram are monitored continuously and documented every 3 – 5 minutes by the nurse.

E. The patient's chin is positioned and the physician inserts the TEE probe. The nurse reinforces the physician's instructions, comforts a reassures the patient.

G. The TEE probe is inserted by the physician to approximately 45 – 50cm to obtain various views, color flow and Doppler. CVT operates the ultrasound machine and captures all images. This is all recorded on the VCR. The procedure lasts approximately 15 0 30 minutes.

4. Post Procedure:

A. The TEE probe is removed gently from the patient and placed in a protective disposable bag for proper cleaning using a disinfectant.

B. Vital signs and respiratory status are monitored as well as patient's general condition.

C. The physician will discuss the preliminary results with the patient and/or family. The physician will later review recording of study and dictate final report, cc referring physician and medical records.

D. Dentures, eyeglasses and personal belongings are returned to the patient.

5. Discharge Planning and Follow-up:

A. The IV saline lock (or 0.9% NaCl solution) is removed, if not indicated for further use. The patient is instructed on safety when ambulating due to sedative effects of possible dizziness, confusion visual disturbance and slower reaction.

B. The patient transferred to recovery by wheelchair or stretcher and a report is given to the receiving nurse. If the patient is an inpatient, the patient will recover in his/her bed.

C. The outpatient is given discharge instructions concerning IV site care, continuing meals and equipment operation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Transesophageal Echocardiography (TEE)

Descriptive Type: New Policy

Document Number: 13-7018

Attachments: None

Author: Duane Iwamura

Typist: Julie Gresham

Creation Date: 02/23/09

Revision Date: 01/17/18

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
Cardiac Cath Committee	~~02/23/09~~	
Radiation Safety Committee	~~02/24/09~~	
Surgery Committee	~~03/18/09~~	
MEC	~~04/08/09~~	
Board of Directors	~~04/22/09~~	

Effective Date: ~~04/23/09~~

Forward To Intranet: Policy Binders (PBX and Administration) and Post to

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Imaging, Centralized Scheduling, Tulare's Pharmacy, Materials Management

FROM: Administration

SUBJECT: Dispensing of Medications and Preps for Outpatient Medical Imaging Procedures

I. POLICY:

The Centralized Scheduling Department works in collaboration with Medical Imaging to schedule and provide instructions to outpatients that are having diagnostic imaging procedures. There are a number of procedures that require the patient to follow preparation guidelines, which involve the use of oral contrast material or a bowel preparation. Oral contrast material is categorized as a medication; therefore, TRMC strives to support patient safety through our medication error reduction program, part of which includes the following procedure.

II. PROCEDURE:

A. Tests Requiring Oral Contrast Material

1. An outpatient that is being scheduled by Central Registration for a procedure that requires the ingestion of oral contrast material prior to the exam (eg, CT Abdomen and Pelvis) will be given an appointment and asked to obtain the oral contrast preparation (eg, ReadiCat) along with instructions from Tulare's Pharmacy.

2. Upon scheduling the patient, Central Registration staff will fax a copy of the imaging request that includes an order for oral contrast, face sheet, and the patient's completed instruction sheet to Tulare's Pharmacy.

3. Having procured a supply of oral contrast (in advance) from Materials Management, Tulare's Pharmacy staff will prepare the medication with proper labeling and dispense to the patient (at no charge) along with the completed instruction sheet.

4. The cost of all oral contrast supplies used for diagnostic imaging will be expensed to the Medical Imaging Department. In turn, the Medical Imaging Department will include the cost of these items into the examination fee.

B. Tests Requiring Bowel Preparation

1. An outpatient that is being scheduled by Central Registration for a procedure that requires a bowel cleansing preparation prior to the exam (eg, Barium Enema, IVP, etc.) will be given an appointment and asked to obtain the preparation along with instructions from Tulare's Pharmacy.

2. Upon scheduling the patient, Central Registration staff will fax a copy of the imaging request, face sheet, and the patient's completed instruction sheet that outlines the use of an over-the-counter bowel preparation to Tulare's Pharmacy.

3. Having procured a supply of Lo-So or comparable bowel prep medications (in advance) from Materials Management, Tulare's Pharmacy staff will dispense it to the patient (at no charge) along with the completed instruction sheet.

4. The cost of all bowel preparation supplies used for diagnostic imaging will be expensed to the Medical Imaging Department. In turn, the Medical Imaging Department will include the cost of these items into the examination fee.

C. Procurement of Supplies

1. The Materials Management Department will order and main a par level supply of Lo-So Bowel Preparation and ReadiCat that will be stored in a secure area.

2. The Medical Imaging Department or Tulare's Pharmacy will procure these items from the Materials Management Department on an "as needed" basis.

3. The cost of these items, when used for Medical Imaging patients, will be expensed to the Medical Imaging Department or CT, as appropriate.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Dispensing of Medications and Preps for Medical Imaging Procedures

Descriptive Type: New Policy

Document Number: 13-7020

Attachments: None

Author: Duane Iwamura, Director, Medical Imaging

Typist: Duane Iwamura/Gillian Busch

Creation Date: 10/19/12

Revision Date: 01/17/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P & T Committee	~~12/07/12~~	
MEC	~~01/09/13~~	
Board of Directors	~~01/23/13~~	

Effective Date: ~~01/24/13~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Clinical Services, Medical Staff, Patient Access

FROM: Administration

SUBJECT: Outpatient Scheduling and Pre-Registration for Imaging Procedures

I. GENERAL CONSIDERATIONS

A. Pre-registration and scheduling for Imaging procedures: General X-rays, Fluoro procedures, Bone Densitometry, Mammography, Ultrasound, Nuclear Medicine, CT, and MRI.

II. SCHEDULING

Procedures can be scheduled Monday through Friday 0800-1630 by telephone on a first-come, first-served basis.

~~Type of service~~	~~Phone number~~	~~Fax number~~
~~Imaging~~	~~559.366.1121~~	~~559.685.3828~~

It is the physician and physician office staff's responsibility to clearly communicate to the patient the need for the exam including providing the script or complete order that the patient must call in to scheduling and bring to the department on the date of service. The physician's office must maintain documentation of the order for services and **will be responsible to obtain any necessary authorization as required by insurance coverage**. The physician's office will instruct the patient to call the scheduling department as indicated above.

1. The physician or physician's office staff will counsel the patient regarding the script and/or explanation of the order for services and direct the patient to contact scheduling with the information below :
    i. Reason for ordering the test or service (diagnosis description, ICD-9 code, sign(s), symptoms)
    ii. Test or service requested
    iii. Provider's name
    iv. Provider's signature
    v. Patient complete name
    vi. Patient date of birth

Effective Date: ~~06/25/15~~

APPROVED:

Medical Executive Comm.: ~~06/10/15~~

Board Of Directors: ~~06/24/15~~

(11) Fiscal & Business
Admitting & Discharge:
Admitting/Registration Policy
13-7021

2. Physicians or their office staff must continue to pursue authorizations for requested services with patient's insurance per guidelines of that coverage.

3. It is recommend as best practice that the physician and/or their office staff keep on file a copy of the order for the expected service in the patients chart in written or electronic format **and** instruct the patient to bring a copy of that order with them on the date of service set up by scheduling staff.

4. Once the patient contacts scheduling, staff will verify that the minimal requirements are met and gather demographic and insurance information for the patient. Scheduling staff will verify insurance coverage and authorization requirements. When all information is verified staff will schedule the appointment for the most available date/time; but, no sooner than the minimum time frame for completion of authorization if authorization is required. Scheduling staff will instruct the patient to bring copy of the physician's order for services when they present for the scheduled service and come in 30 minutes prior to their scheduled appointment do complete registration paperwork.

5. Prior to the scheduled date of service, scheduling/pre-registration staff will follow cases requiring authorization to confirm that authorizations are granted.
    a. If authorization is not granted by the payer by 1200 on the day prior to scheduled service, scheduling staff will notify the patient that the service will need to be rescheduled per the hospital defer/delay policy.
    b. Scheduler will call the physician office and let them know we have not received the authorization and we have rescheduled the patient.
6. STAT orders- Stat orders will be handed to the patient at the time of visit and brought with the patient directly to the hospital for services

III. PRESENTING FOR SERVICE

On the date of service, patient will present to main registration to check-in, sign final documents, present physician order for service, and be escorted to the service area.

If patients present on the date of service without the copy of their written order for service from their physician the patient will be rescheduled for a later date.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Outpatient Scheduling and Pre-Registration for Imaging Procedures
Descriptive Type:	New
Document Number:	13-7021
Attachments:	None
Author:	Alan Germany and Christine Adams
Typist:	~~Melissa Arend~~a Jeff Bese
Creation Date:	05/05/15
Revision Date:	~~N/A~~01/17/18
Prev. Dist. Date:	N/A

Committee Review and Approval:	Approval Date:	Comments:
Medical Imaging Committee	~~06/01/15~~	
MEC (if applicable	~~06/10/15~~	
Board of Directors	~~06/24/15~~	

Effective Date:	~~06/25/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Respiratory Care, Nursing Services and Medical Staff

FROM: Administration

SUBJECT: Impedance Threshold Device (ResQPOD)

I. POLICY:

A. It is the policy of the Tulare Regional Medical Center Respiratory Care Department to provide clinically proven treatments to improve the patient's cardiopulmonary status. These treatments must be ordered by members of the patient's health care team, who are licensed and approved to write such orders.

II. DESCRIPTION:

A. "ResQPOD" is an impedance threshold device which is used in conjunction with a manual resuscitation bag and mask and/or artificial airway which aids resuscitative efforts by creating a negative pressure (vacuum) in the patient's thoracic cavity during chest recoil while CPR is in progress. This allows for greater perfusion throughout the patient's body systemically by increasing venous return.

III. OBJECTIVES:

A. Increase in blood pressure
B. Increase in cardiac output
C. Increase in survival from sudden cardiac arrest
D. Improve the opportunity for complete neurological recovery

IV. INDICATIONS:

A. Pulseless and non breathing individuals over 8 years of age.

NOTE:

There is evidence that the ResQPOD may be effective any patient over 10 kg, though the device is not recognized for use in a pediatric population. It is at the discretion of the physician to determine if the ResQPOD should be utilized during pediatric resuscitation.

V. CONTRAINDICATIONS:

Effective Date:

Approved:

Medical Executive Comm.:

Board of Directors:

(13) Ancillary Services
Respiratory Care:
Impedance Threshold Device
(ResQPOD)
13-8027

A. The ResQPOD has the following **absolute contraindications** and should not be used on patients with:
   - Flail Chest
   - Uncontrolled Hemorrhage

B. The ResQPOD has listed **contraindications** in individuals with history of:
   - Chest pain
   - Shortness of breath
   - Pulmonary Hypertension/Aortic Stenosis
   - Dilated cardiomyopathy and or congestive heart failure

NOTE:
It is at the discretion of the physician whether the ResQPOD should be used in patients with these histories to improve perfusion while addressing the immediate problem of cardiac arrest. The ResQPOD helps treat the primary problem of low circulation experienced by the patient in cardiac arrest receiving CPR. Once that problem has been effectively treated, the ResQPOD is no longer indicated or appropriate in view of other medical conditions—such as the listed contraindications—as it can worsen them. Thus, if used, it should be removed immediately once a pulse has been obtained.

C. Children under 8 years of age

VI. ADDITIONAL INFORMATION:

A. In order to ensure effectiveness of the "ResQPOD", you MUST have a good seal either with mask and/or the cuff of ET tube.
B. Use of the "ResQPOD" should be terminated/discontinued immediately once patient regains a pulse or spontaneous breathing as ordered by a physician and/or licensed practitioner (e.g. RCP, RN). The ResQPOD should be used with a patient that is gasping or displaying an agonal breathing pattern as long as CPR performed.
C. Spontaneously breathing patients must inspire greater than -10 to -16 cmH_2O in order breathe against the valve of the device.

D. Not recommended to be used > 30 minutes.

VII. INSTRUCTIONS FOR USE:

A. With a resuscitation bag and mask:
   1. Attach bottom of the "ResQPOD" directly to the face mask.
   2. Attach the bag patient port to the top end of the "ResQPOD", making sure that all connections are snug.

3. Once assembled, turn on ventilatory timing light on and begin to ventilate the patient per American Heart Association (AHA) standards or as ordered by a physician.
4. If patient regains a pulse, discontinue ResQPOD use immediately.

B. With a resuscitation bag and artificial airway (ET tube or Tracheostomy tube:
1. Attach bottom of the “ResQPOD” directly to the artificial airway.
2. Next attach the bag patient port to the top end of the “ResQPOD”, making sure that all connections are snug.
3. Once assembled, turn on ventilatory timing light and begin to ventilate the patient per AHA standards or as ordered by a physician.
4. If patient regains a pulse, discontinue ResQPOD use immediately.

VIII. WARNING:

A. If respiratory distress should develop during the use of “ResQPOD”, immediately cease use of the device and inform the physician.

IX. CLEANING:

A. Disposable. Single patient use only!

References:

Plaisance, P., et al. (2004). Evaluation of an impedance threshold device in patients receiving active compression-decompression cardiopulmonary resuscitation for out of hospital cardiac arrest. *Resuscitation, 61(3), 265-271.*

Zoll Medical Corporation. (2015). ResQPOD Frequently Asked Questions. Retrieved January 25, 2018 from https://www.zoll.com/medical-products/impedance-threshold-device/resqpod/literature/.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Impedance Threshold Device (ResQPOD)

Descriptive Type: Revised

Document Number: 13-8027

Attachments: None

Author: Lionel Machado

Typist: Christa Cunningham

Creation Date: 11/10/08

Revision Date: 01/25/18

Previous Dist. Date:

Committee Review:	Approval Date:	Comments:
ICU/Medicine Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post on Intranet

Disposition: Copy and Distribution – Administration

Comments:

This policy to be removed. No longer applicable.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

~~TO: Medical Imaging, Clinical Nursing Services, PBX and Medical Staff~~

~~FROM: Administration~~

~~SUBJECT: STAT After Hour Electroencephalogram (EEG)~~

~~**I. PURPOSE:**~~

~~Define the appropriate guidelines for ordering and obtaining STAT Electroencephalogram studies outside of normal business hours.~~

~~**II. POLICY:**~~

~~A. Neurology services are available on a limited basis during the hours outside of normal business hours.~~

~~B. In the event that an STAT EEG is required, the following procedure will serve as a guideline in securing the appropriate services.~~

~~**II. PROCEDURE:**~~

~~A. The ordering physician (with the exception of the Emergency Department Physician) requesting a STAT or Emergency EEG study (after normal business hours), or the nurse in charge of the patient's care must first contact a Neurologist on staff in order to validate the appropriateness for the STAT order (Note: Approved indications for a STAT EEG may include Brain death determination, new onset seizure activity, etc.). It is also necessary to confirm that the Neurologist will be available to provide a STAT interpretation immediately following the examination.~~

~~B. After obtaining approval from the Neurologist, the nursing unit will notify PBX and or the Respiratory Therapy department personnel to contact the EEG tech. PBX and or the Respiratory Care department personnel will put the tech in contact with the appropriate nurse so that accurate information can be shared concerning the STAT request. Nursing will also provide the tech with~~

the name of the Neurologist that has approved the procedure and inform him or her of any information relative to such (i.e., if the Neurologist will be present during the study; how to contact the Neurologist after the exam has been completed, etc.). If the Respiratory Care department personnel or PBX is unable to contact the EEG tech, the operator will then attempt to contact an alternate EEG Tech, until a successful contact is made. If their efforts are unsuccessful, please contact the Director of Respiratory Care Services for assistance.

C. The EEG tech will arrive in a timely fashion in response to the STAT request. He or she will perform the procedure accordingly and insure that the exam is available to the Neurologist for timely interpretation. The technologist will notify the Neurologist immediately upon completion of the examination.

D. The Neurologist will review the examination and notify the appropriate individual (i.e., referring physician, RN, etc.) of the results.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: STAT After Hour Electroencephalogram (EEG)

Descriptive Type: Revised

Document Number: 13-8032

Attachments: None

Author: Lionel Machado

Typist: Melissa Arend

Creation Date: 03/28/12

Revision Date: 11/13/15

Prev. Dist. Date: 07/26/12

Committee Review and Approval:	Approval Date:	Comments:
Intensive Care/Respiratory Therapy	04/11/16	
Medicine Service	04/20/16	
MEC	05/11/16	
Board of Directors	05/25/16	

Effective Date: 05/26/16

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Respiratory Care, Nursing Services and Medical Staff~~All Departments~~

FROM: Administration

SUBJECT: EzPAP

PURPOSE:

EzPAP is a~~n~~ device used for the application of positive expiratory pressure (PEP) to prevent~~/ and~~ treat atelectasis and ~~also~~ aid~~s~~ in lung expansion.

INDICATIONS:

- To reduce air trapping in asthma and COPD
- To aid in mobilization of retained secretions (in cystic fibrosis and chronic bronchitis~~).~~
- To prevent or reverse atelectasis
- To optimize delivery of bronchodilators in patients receiving bronchial hygiene therapy.

CONTRAINDICATIONS:

- Although no absolute contraindications exist, the following should be carefully evaluated before initiating PEP therapy.
    - Patients unable to tolerate the increased work of breathing
    - Intracranial pressure (ICP > 20 mmHg)
    - Hemodynamic instability
    - Recent facial, oral, or skull surgery or trauma
    - Acute sinusitis
    - Epistaxis
    - Esophageal surgery
    - Active hemoptysis
    - Nausea
    - Known or suspected tympanic memb~~e~~rane rupture or other middle ear pathology
    - Untreated pneumothorax~~.~~

Effective Date: ~~02/25/16~~

APPROVED:

Medical Executive Comm.: ~~01/27/16~~

Board Of Directors: ~~02/24/16~~

(13) Ancillary Services:
Respiratory Therapy
EzPAP
13-8033

- Cardiovascular insufficiency~~:~~ ~~i~~fPEP therapy ~~IPPB~~ causes evidence of exacerbation of condition~~.~~ (e.g.~~i.e.~~ hypotension, hypovolemia, arrhythmias, and coronary artery insufficiency).
- Subjective deterioration~~:~~ (e.g. ~~If~~ patient is unable to use device~~IPPB~~ correctly, ~~or if~~ the treatment causes the patient distress.

EQUIPMENT:

- EzPAP
- Manometer
- Flow meter (2 flow meters are needed if PEP therapy and aerosol treatments are to be given concurrently.)
- Stethoescope

PROCEDURE:

- Upon receiving physicians orders:
  - Review chart for accurate orders and other pertinent information including history, medications, progress notes and therapist notes. Review of chart for accurate orders must be done by each shift.
  - Locate and identify patient, introduce yourself and explain procedure and purpose. Make effort to enlist maximum cooperation.
  - Ask patient to identify his/her name and date of birth if able.
  - Wash hands
  - Bring equipment to patient bedside.
  - Assemble device~~setup~~.
  - Inject medication into nebulizer (if using in conjunction with EzPAP)
  - Obtain vital signs and breath sounds. ~~(~~If pulse increases by 25% or increases to a frequency above 150, discontinue treatment and notify physician~~)~~.
  - TWO flow meters must be used to deliver PEP therapy and nebulized medication.
  - Set flow rate (air or oxygen flow meter) for both nebulizer and EzPAP.
    NOTE: Set flow for patient tolerance
    - Set E~~z~~ZPAP flowmeter between 5 – 15 L/min~~PM~~. Recommended 6 – 8 L/min to start.
    - PE~~E~~P will vary with respiratory effort. Rapid inspiration will decrease PE~~E~~P level.
  - Ensure the flow meter is set as indicated.
  - Have the patient sit up with elbows resting comfortably at side or on bedside table. Instruct the subject to relax while performing slow, deep, diaphragmatic breathing.
  - Place the mouthpiece in the patient's mouth and instruct to breathe easily against the pressure from the device. (Note: A resuscitation~~n Ambu~~ bag mask may be used if patient cannot create a seal with the mouthpiece)

- Be sure patient maintains a tight seal on the mouthpiece during therapy
- Instruct the patient to breath diaphragmatically
- Slow inhalations and exhalations by the patient will maintain adequate airway positive pressure during the breathing cycle.
- Duration of treatment is 10-15 minutes.
  - Treatment is considered complete after all medication has been nebulized (if applicable).
- Therapist must stay with the patient during the entire treatment.
- Obtain vital signs post treatment and ~~then~~ wash hands after completion of treatment.
- Document therapy.

HAZARDS/COMPLICATIONS:

- Increased work of breathing
- Increased intracranial pressure
- Cardiovascular compromise
- Air swallowing
- Pulmonary barotrauma
- Acute pneumonthorax which is being managed without an intercostal tube.

RESPONSE TO COMPLICATIONS:

- If treatment is causing nausea, discontinue the treatment and notify physician.
- If patient complains of severe pain and cause of pain is uncertain and therapist is unable to make necessary adjustments to reduce pain, discontinue treatment and notify physician. If patient has had abdominal surgery, abdominal pain may be diminished by firmly pressing a pillow against abdomen (s~~S~~plinting) during treatment. This will also help reduce pain when patient coughs.
- If there is a significant increase in pulse (~~usually above~~ 25% above baseline) discontinue treatment and notify physician.

INFECTION CONTROL:

- Observe universal precautions as appropriate.
- Device is ~~S~~single patient use and should be disposed of at completion of therapy and or changed out every 5 days.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: EzPAP

Descriptive Type: Revised Policy

Document Number: 13-8033

Attachments: None

Author: Lionel Machado

Typist: Christa Cunningham~~Melissa Arend~~

Creation Date: 07/25/12

Revision Date: ~~10/15/15~~01/10/18

Prev. Dist. Date: ~~12/11/12~~

Committee Review and Approval:	Approval Date:	Comments:
Medicine Services Committee	~~11/04/15~~	
MEC	~~01/27/16~~	
Board of Directors	~~02/24/16~~	

Effective Date: ~~02/25/16~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Release of Information – Patient, Medical and/or Medical Records/ Access to Minimum Necessary Protected Health Information (HIPAA)

I. PURPOSE:

To maintain the patient's right to confidentiality of his/her medical information. To define the methodology whereby Tulare Regional Medical Center to release patient health information in compliance with all state and federal laws, rules and regulations. To uphold the patient's right to access their own health information in compliance with state and federal laws, rules and regulations, without infringement on the patient's right to privacy and confidentiality. HIPAA Privacy Rule 164.502(b) indicates that Tulare Local Health Care District (and its employees) must minimize the use and disclosure of protected patient health information. Only when it is *necessary* to accomplish an appropriate purpose should protected health information be used, disclosed, or requested. Federal law refers to this as the "minimum necessary" standard.

II. POLICY:

A. Tulare Regional Medical Center recognizes that privacy is a fundamental right, which is recognized in the state and federal constitutions. With regard to medical information, California's statutes provide confidentiality (e.g., the Confidentiality of Medical Information Act). In addition, evidentiary privileges protect the disclosure of certain information (e.g., the physician-patient privilege, the sexual assault victim-counselor privilege, etc.). At the federal level, privacy protection is provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), effective April 14, 2003 [45 C.F.R. parts 160 and 164.

B. The Health Information Management Department (HIM) will provide a system for timely and accurate processing of requests and for the release of information from closed medical records maintained by the hospital.

C. The medical record is the property of the TRMC. Release of the record, copies of the record or patient identifiable information contained in the record

is within the discretion of the TRMC, except as otherwise controlled by law. A release of information process shall be established to comply with all applicable state and federal laws, regulations and accrediting standards and to comply with generally accepted principles of patient's rights, privacy and confidentiality. All TRMC personnel will safeguard all health information records against loss, tampering, use by unauthorized persons, and damage.

D. Business hours for access to records are from 8:00 a.m. to 4:30 p.m. Monday through Friday, except holidays.

III. DEFINITIONS:

A "Closed Medical Records" describes a completed record after discharge or after services have been provided.

B. "Open Medical Records" indicates the patient is still a patient in the hospital or not yet discharged from the facility.

IV. PROCEDURE:

A. Patient access to their own health information:

1. The patient or a patient's representative must provide sufficient identification and requests must be in writing to access their closed medical records.

2. If the patient is the employee and the employee wants copies of his/her own records, an authorization must be completed in the Health Information Management Department and access/copies provided by HIM. It is inappropriate for employees to access their own health records on TRMC computer resources. Each time the employee wants to view or copy records, an authorization must be signed in the HIM department.

3. The following outlines who must be recognized as the personal representative for each situation:

   a. An adult or an emancipated minor – A person with legal authority to make health care decisions on behalf of the individual.

   b. An unemancipated minor – A parent, guardian, or other person acting with legal authority to make health care decisions on behalf of the minor child.

c. Deceased patient – A person with legal authority to act on behalf of the decedent or the estate (not restricted to health care decisions).

4. Upon written request by a patient or a patient's representative, the requestor is entitled to inspect and/or obtain copies of all or part of the patient's closed medical record. The following types of medical information are maintained by TRMC:

a. Health history

b. Diagnosis

c. Conditions

d. Treatment or proposed treatment of a patient or former patient

5. Mental Health records request must be approved by the Health Care Provider. In these cases, if a provider denies access in whole or in part, a written notice must be given to the patient within five working days.

6. Patients can request to view their closed or open medical record without obtaining a copy. An appropriate person from Health Information Management (HIM), patient's nurse or Risk Manager will assist the patient with their review. An authorization (Exhibit A) must be completed by the patient or legal representative prior to accessing the record. If the patient verbally agrees to allow family/friends access to information in their "open records", the caregiver must document the disclosure on a release of information form. The caregiver must sign, date and indicate what information was discussed.

7. Patients can request copies of their open medical record by completing the proper request. The patient must understand the record is not complete and the physician has 14 days to complete the discharge summary for an "acute" stay. Patients are encouraged to obtain records after they are discharged for this reason but will not be denied copies of their record while the record is still open. If the patient still wants copies of certain parts of the record before discharge, the caregiver should contact Health Information Management ~~at extension 3402~~ and a HIM specialist will provide the requested copies after an authorization is obtained.

B. Other releases of patient information:

1. General patient information (Refer to CHA Consent Manual for specific details.

2. Health information must be disclosed if disclosure is required by any of the following:

   a. Court order

   b. Board, commission or administrative agency for adjudication

   c. Subpoena

   d. Arbitration

   e. Search warrant

3. Health information may be disclosed without patient authorization under the following circumstances:

   a. To health care providers if the information is necessary for purposes of diagnosis or treatment of the patient.

   b. To assist other providers in obtaining payment for health care rendered.

   c. For billing purposes to the extent necessary to determine responsibility for payment and to secure payment (i.e., insurer, employer, health care service plan, governmental authority, medical data processing, or any other responsible party).

   d. For peer review purposes within TRMC.

   e. For purposes of licensure or accreditation.

   f. To the coroner in the course of investigation.

   g. To tumor registries for reporting purposes.

   h. To a patient's employer, provided the disclosure is limited to the information which was created as a result of employment related health care services performed at the specific written request and expense of the employer (the patient will be informed that this information will be given to their employer).

   i. For civil, administrative or criminal investigations

   j. To a health oversight agency.

k. To report suspected abuse, neglect or domestic violence.

4. Public release of information without authorization shall be limited to the patient's presence in the facility and general condition. The procedures in AP.103 Public Release of Patient Information shall be followed.

5. Except as noted above, requests for health information shall not be honored without obtaining a valid authorization. The authorization shall be in the format of Exhibit A.

6. An authorization will be considered invalid if any of the following exists:

   a. There is a question as to the identify or authenticity of the signature of the person presenting the authorization.

   b. There is doubt as to the competency of the person who signed the authorization.

   c. There is doubt as to the signer being 18 or older.

   d. There is a question as to the legal status of the guardian, conservator, etc.

   e. There is reason to know that the patient does not want the authorization honored.

   f. The requirement of the hospital policies have not been met The records requested are psychiatric records or drug and alcohol abuse records

7. Alcohol/drug abuse patient information (Refer to CHA Consent Manual for specific details) – All requirements in Section A above and the following apply:

   a. To program personnel who need the information in connection with their duties to treat the patient.

   b. Qualified ancillary services.

   c. Crimes on program premises or against TRMC personnel.

   d. Child abuse reports.

   e. Veteran's administration and armed forces.

f. Medical emergencies.

g. Research activities.

h. Audit and evaluation activities.

i. Vital statistics required by law.

j. Court authorization required.

8. Court authorization is required for release of information in response to a subpoena or other legal process.

9. Release of information with authentic patient authorization is required in all other circumstances, except as stated in 1-F.

C. Psychiatric patient information (Refer to CHA Consent Manual for specific details) – All requirements in Section A above and the following apply:

1. Health information may be disclosed, without patient authorization under the following circumstances:

a. Professionals within the facility who are providing services or referrals.

b. Professionals serving on multidisciplinary teams.

c. Third-party payers or other persons or organizations in connection with processing a claim for aid, insurance or medical assistance.

d. Researchers (provided all research is carried out according to the rules developed by the State Director of Mental Health or the State Director of Development Services.

e. To government law enforcement officials in certain circumstances.

f. To the State Department of Justice if patient has been committed to the State Department of Mental or to a state mental hospital for observation as a mentally disordered sex offender.

g. Youth Authority and Adult Correctional Agency or any component thereof.

h. Courts as necessary for the administration of justice.

i. To authorized licensed and certified professionals in the field for compilation and publication of statistical data.

j. To a quality assurance committee.

k. To a qualified individual for purposes of genetic testing (refer to CHA Consent Manual for additional information.

D. General release of requested medical information:

1. All requests for medical information from outside the TRMC shall be directed to the Health Information Management Department. HIM shall log and maintain a record of all requests and transactions. The log shall be retained for a minimum of six (6) years.

2. Health Information Management must assure that the copies are transmitted to the patient within 15 days after the written request is received. These copies may be mailed or picked up by the requestor. Documentation must be retained on the health information provided.

3. If health information is requested over the telephone or via facsimile, the requesting party will be called back to verify the person or institution. Information may be given over the phone to authorized agencies (Worker's Compensation Appeals Board, worker's compensation employers, contractual carriers of worker's compensation insurance or other payers as related to specific claims).

E. Release to Copy Services and Charges for Records:

1. The following charges will be applied when providing copies of medical records:

a. $15.00 for processing the request and retrieving the record.

b. Ten (10) cents per page copied.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274
559.688.0821 • www.TulareRegional.org

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and use of your personal health information. Failure to provide all information requested in this form may invalidate this authorization.

Patient Name: _____ Date of Birth _____

Telephone Number: _____ Medical Record Number _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby, authorize Tulare Local Healthcare District DBA Tulare Regional Medical Center to release my personal health information to:

_____
Persons/Organization(s) authorized to receive the information

_____
Address: Street City State Zip Code

The following information:

- ❑ Pertinent information (Discharge Summary, History & Physical, Operative Report,)
- ❑ Laboratory Results
- ❑ Emergency Department Reports
- ❑ Medical Imaging Reports
- ❑ Medical Imaging Films (Computerized Disc)

Other reports- please specify: _____

I specifically authorize release of the following information (check as appropriate):

- ❑ Alcohol/ Drug Treatment Information
- ❑ HIV Test Results
- ❑ Mental Health Treatment Information

Covering the period(s) of healthcare: From (date: _____ to (date):_____

Form O # 516 REV. 3/13

PURPOSE

Purpose of requested use or disclosure:
- ❑ Patient request
- ❑ Other (please specify) _____

EXPIRATION

This authorization expires on (date) _____

MY RIGHTS

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but I must do so in writing and submit it to:

Tulare Regional Medical Center
869 Cherry Street
Tulare, CA 93274
Attn: Health Information Management

My revocation will take effect upon receipt, except to the extent others have acted in reliance upon this authorization.

I have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

_____ _____ _____
(Patient / Legal Representative) Date Time

If signed by other than patient, indicate relationship: _____

Print name (legal representative): _____

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274
559.688.0821 • www.TulareRegional.org

AUTORIZACIÓN PARA USO O DIVULGACIÓN DE INFORMACIÓN MÉDICA

Al completar este documento se autoriza la divulgación y el uso de su información médica personal. Dejar de suministrar toda la información solicitada en este formulario puede invalidar la autorización.

Nombre del paciente:_____ Fecha de nacimiento _____

Número de teléfono:_____ Número de historia clínica _____

USO Y DIVULGACIÓN DE INFORMACIÓN MÉDICA

Por medio de la presente, autorizo a Tulare Local Healthcare District DBA Tulare Regional Medical Center a divulgar mi información médica personal a:

_____
Personas/Organización(es) autorizada(s) para recibir la información

_____
Dirección: Calle Ciudad Estado Código postal

La siguiente información:

- ❑ Información pertinente (Resumen de alta médica, Antecedentes y exploración física, Informe operatorio)
- ❑ Resultados de análisis de laboratorio
- ❑ Informes del Departamento de Emergencias
- ❑ Informes de diagnósticos por imágenes
- ❑ Películas de diagnósticos por imágenes (Disco computarizado)

Otros informes- especificar: _____

Autorizo específicamente la divulgación de la siguiente información (marque la(s) opción(es) que corresponda(n)):

- ❑ Información sobre tratamiento por drogas/alcohol
- ❑ Resultados de prueba de HIV
- ❑ Información sobre tratamiento de salud mental

Cobertura del/los período(s) de cuidados médicos:
Desde (fecha): _____ hasta (fecha):_____

Form O # 515 REV. 3/13

PURPOSE

Propósito del uso o la divulgación solicitados:
- ❑ Solicitud del paciente
- ❑ Otro (especificar) _____

EXPIRATION

Esta autorización vence el (fecha) _____

MY RIGHTS

Puedo rehusarme a firmar esta autorización. La negativa no afectará mi capacidad de obtener tratamientos o pagos o la aptitud para recibir beneficios.

Puedo inspeccionar u obtener una copia de la información médica para la cual se me solicita permitir el uso o la divulgación.

Puedo revocar esta autorización en cualquier momento, pero debo realizarlo por escrito y enviar la revocación a:

Tulare Regional Medical Center
869 Cherry Street
Tulare, CA 93274
A la atención de: Health Information Management

Mi revocación surtirá efecto ni bien se reciba, excepto que otros hayan actuado en virtud de esta autorización.

Tengo derecho a recibir una copia de esta autorización.

La información divulgada concerniente con esta autorización puede volver a ser divulgada por el receptor. Esta nueva divulgación en algunos casos no está prohibida por la Ley de California y podría dejar de estar protegida por la Ley de confidencialidad federal (HIPAA). Sin embargo, la ley de California prohíbe que la persona que recibe mi información realice otras divulgaciones a menos que obtenga otra autorización para dicha divulgación por parte mía o a menos que dicha divulgación se solicite o se permita específicamente por ley.

SIGNATURE

_____
(Paciente / Representante legal) Fecha Hora

Firmé en lugar del paciente, indicar vínculo:_____

Nombre en letra imprenta (representante legal):_____

Descriptive Name:	Release of Information – Patient, Medical and/or Medical Records
Descriptive Type:	Revised
Document Number:	13-9001
~~Attachments:~~	~~Authorization for Use or Disclosure of Health Information~~
Author:	Phyllis Gregory~~/Andrea Carrasco/Ena Menezes~~
Typist:	Melissa Arend/Andrea Carrasco/Ena Menezes
Creation Date:	12/14/88
Revision Date:	~~11/18/15~~ 02/09/18
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Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~01/26/16~~	

Effective Date:	~~01/27/16~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Records

FROM: Administration

SUBJECT: Patient Right to Access to Protected Health Information (PHI) (HIPAA)

Under California law, patients have a right of access to their protected health information (PHI) that is used, in whole or in part, to make decisions about them.

The hospital staff must provide access to patients for as long as the PHI is maintained in a designated record set.

The types of information to which patients do not have a right of access, even if the information is maintained in a designated record set are:

1) Psychotherapy notes,

2) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding,

3) Certain protected health information maintained by a covered entity that is subject to or exempted from the Clinical Laboratory Improvements Amendments of 1988 (CLIA). The hospital staff may, but are not required to, provide access to this information.

4) Any other information or document under California law, that does not constitute a patient record,

5) Records protected by state law governing the confidentiality of communicable disease carriers.

Requests for Access and Timely Action

The law allows five (5) working days before inspection of the record and fifteen (15) working days before copies must be completed. The request for access must be made in writing and must provide sufficient information to identify the patient and/or legal representative. Employees who wish to access their own medical records shall submit

a written authorization form in accordance with this policy. A release form is available to facilitate such a request. (See Attached)

All requests for access/inspection of the PHI must be immediately referred to and reviewed by the Privacy Officer. The Privacy Officer or designee will have the responsibility to review and determine if the request will be accepted or rejected. The Privacy Officer will generally request a designee to respond to all requests for patient access to the PHI and initiate the arrangements, within two (2) working days of receipt of the request, to comply with the request. The designee will give a copy of the request to the Privacy Officer.

When the hospital accepts a request for access to patient records, in whole or in part, it must notify the patient of the decision and provide the access requested. Patients have the right both to inspect and to copy protected health information in a designated record set. The patient may choose whether to inspect the information, to copy the information, or to do both.

The PHI will be reviewed by the Director of Medical Records or designee, prior to permitting inspection or providing copies to ensure, at least:

1) integrity of the record,

2) completeness of the record,

3) removal of any portion of the record relating to someone other than the patient,

4) removal of any information furnished in confidence by someone other than the patient or by the patient in the event a legal representative is going to review the record,

5) appropriateness of requests from minor patients,

6) consideration of possible adverse response from patients whose condition(s) may be psychiatric/psychology, alcohol or drug abuse, or other related.

In the event the patient requests a copy of the PHI, the copy will be made available to the requester after review of the packet is completed by the Director of Medical Records or designee.

If the same protected health information is maintained in more than one designated record set or at more than one location, the hospital staff is required to produce the information only once per request for access.

The staff must provide the information requested in the form or format requested if it is readily producible in such form or format.

Should the information not be available in the form or format requested, the staff must produce a readily readable hard copy of the information or another form or format to which the individual and covered entity can agree.

If the patient agrees, including agreeing to any associated fees, the staff may provide access to a summary of information rather than all protected health information in a designated record set. As an alternative, the staff may provide an explanation in addition to the protected health information, if the patient agrees in advance to the explanation and any associated fees.

For requests to inspect information that is maintained electronically, the staff may print a copy of the information and allow the patient to view the printout on-site.

The staff may discuss the request with the patient as necessary to facilitate the timely provision of access.

If the patient requests a copy of protected health information, the staff may charge a reasonable, cost-based fee for the copying, including the labor and supply costs of copying. If hard copies are made, this would include the cost of paper. If electronic copies are made to a computer disk, this would include the cost of the computer disk. The hospital may not charge any fees for retrieving or handling the information or for processing the request.

If the patient requests an explanation or summary of the information provided, and agrees in advance to any associated fees, the staff may charge for preparing the explanation or summary as well.

Appointments to review the PHI will normally be made during office hours, Monday through Friday, 8:00am to 4:30 pm, except holidays. However, in those situations where requests are for a time frame other than those normally available, every effort will be made to accommodate the request.

Inspection will be carried out in a private area under the direct visual supervision of the Director of Medical Records or designee.

One individual may accompany the patient or representative during the inspection. **NO CHILDREN**, with the exception of the patient, will be permitted during the inspection. The patient may choose one additional person to participate, if desired.

During the patient review or review by patient's representative of the medical record, the person supervising the review will not attempt to explain or interpret anything in the record. The patient or patient's representative will be referred to the physician for any necessary assistance in understanding the information contained in the record.

Denial of Access

The hospital staff can deny a patient access to inspect and copy protected health information about them for the following reasons:

1) The hospital may deny a patient access to any information that is excempted from the right of access discussed above.

2) If the hospital staff is treating a patient from a correctional institution, an inmate's request to obtain a copy of protected health information may be denied if obtaining a copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates or the safety of any officer, employee or other person at the correctional institution or responsible for the transporting of the inmate.

   This ground for denial is restricted to an inmate's request to obtain a copy of protected health information. If an inmate requests inspection of protected health information, the request must be granted unless one of the other grounds for denial applies.

3) The staff may deny patients access to protected health information that is also subject to the Privacy Act. If protected health information that is contained in records that are subject to the Privacy Act, such denial may be permitted under the Privacy Act.

4) The staff may deny a patient access to protected health information if the hospital obtained the requested information from someone other than a health care provider under a promise of confidentiality and such access would be reasonably likely to reveal the source of the information.

The hospital may deny access to protected health information under certain circumstances in which the access may harm the patient or others.

The hospital may only deny access for these reasons if the covered entity provides the individual with a right to have the denial reviewed.

There are three types of denials for which the hospital must provide the patient with a right to review. A denial under these provisions requires a determination by a licensed health care professional (such as a physician, physician's assistant, or nurse) based on an assessment of the particular circumstances and current professional medical standards of harm.

1) The hospital may deny patient access to protected health information about them if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. Under this reason for denial, the staff may not deny access on the basis of the sensitivity of the health information or the potential for causing emotional or psychological harm.

2) The staff may deny an individual or personal representative access to protected health information if the information requested makes reference to someone other than the individual (and other than a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause serious harm to that other person.

3) The hospital staff is permitted to refuse to treat a personal representative as the patient, generally, if the hospital has a reasonable belief that the patient has been or will be subjected to domestic violence, abuse or neglect by the personal representative, or that treating the personal representative as the patient may endanger the patient and, in its professional judgment, the staff decides that it is not in the best interest of the patient to treat such person as the personal representative.

The staff may deny a request to inspect or copy protected health information if the information is requested by a personal representative of the patient and a licensed health care professional determines that, in the exercise of professional judgment, such access is reasonably likely to cause substantial harm to the patient who is the subject of the information or to another person.

The staff licensed healthcare professional need not have a reasonable belief that the personal representative has abused or neglected the patient and the harm that is likely to result need not be limited to the individual who is the subject of the requested protected health information. Therefore, the staff can recognize a person as a personal representative but deny such person access to protected health information as a personal representative.

Should the hospital staff deny access, in whole or in part, it must, to the extent possible, give the patient access to any other protected health information requested after excluding the protected health information to which the hospital has a ground to deny access.

The staff must exclude only the information that falls within one or more of the denial criteria described above and permit inspection and copying of all remaining information, to the extent it is possible to do so.

The written denial should include a direct reference to the section of the HIPAA regulation relied upon for the denial as well as how the patient can complain to the hospital and the Secretary and must include the name or title and the telephone number of the hospital's Privacy Officer or the person responsible for receiving complaints.

Review of a Denial of Access

If the hospital staff denies the request on the basis of one of the reviewable grounds for denial described above, the patient has the right to have the denial reviewed by a licensed health care professional designated by the hospital who did not participate in the original decision to deny access. The reviewing official must determine, within a reasonable period of time, whether or not to deny the access requested.

If the staff denies a request on the basis of one of the reviewable grounds for denial, the written denial must describe the patient's right to a review of the denial and how the patient may exercise this right.

If the hospital staff denies a request because it does not maintain the requested information, and the staff knows where the requested information is maintained, the staff must inform the patient where to direct the request for access.

The hospital staff must promptly provide the patient with written notice of the reviewing official's decision and otherwise carry out the decision in accordance with the requirements of the regulations.

It will be the responsibility of the Privacy Officer or designee to ensure that all denials and reviews are properly documented in the patient's record.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby, authorize TULARE LOCAL HEALTH CARE DISTRICT to disclose the following information from the medical records of:

   Patient Name:_____ Date of Birth:_____

   Telephone Number: _____ Patient Number_____

   Covering the period(s) of healthcare: From (date:_____ To (date):_____

2. Information to be disclosed:

   ☐ Complete health record(s) ☐ Progress Notes ☐ Discharge Summary

   ☐ Laboratory Tests ☐ History & Physical ☐ X-ray Reports

   ☐ Consultation(s) ☐ ER Reports ☐ X-ray Films

   ☐ Other (Please specify):_____

   I understand that this will include information relating to (check if applicable):

   ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

   ☐ Psychiatric Care

   ☐ Treatment for alcohol and/or drug abuse

3. This information is to be disclosed to _____ for the purpose of_____.

4. I understand this authorization maybe revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.

5. The physician and employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Patient Signature Date Witness Signature

_____ _____

Legal Representative Relationship to Patient

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DENIAL OF ACCESS TO PROTECTED HEALTH INFORMATION

The hospital has determined that your request for access to the following protected health information must be denied due to the reason checked below.

Patient Name: _____

Date of Request	Type of Information Requested

By law, the types of information to which patient do not have a right of access are:

- ☐ Psychotherapy Notes,
- ☐ Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, or
- ☐ Certain protected health information maintained by a covered entity that is subject to or exempted from the Clinical Laboratory Improvements Amendments of 1988 (CLIA). The hospital staff may, but are not required to, provide access to this information.
- ☐ Any other information or document under California law, that does not constitute a patient record,
- ☐ Records protected by state law governing the confidentiality of communicable disease carriers.

Other circumstances that may have resulted in your denial are:

- ☐ The patient is an inmate and obtaining such copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates, or the safety of an officer, employee, or other person at the correctional institution or responsible for transporting the inmate.
- ☐ The individual's access to protected health is subject to and may be denied under the Privacy Act, 5 USC 552a.
- ☐ The protected health information was obtained from someone other than a healthcare provider under a promise of confidentiality and access to the requested information would likely reveal the source of the information.
- ☐ The hospital does not maintain the requested information.
- ☐ The hospital does not maintain the requested information, however, the individual may request the information from the following:

_____

_____

The hospital will allow the patient to request a review if denial is made for any of the following reasons:

- ☐ The hospital staff has determined that the access requested is reasonably likely to endanger the life or physical safety of the patient or another person.

- ☐ The staff may deny an individual access to protected health information if the information requested makes reference to someone other than the patient (and other than a healthcare provider).

- ☐ The staff is permitted to refuse to treat a personal representative as the patient, generally, if the hospital has a reasonable belief that the patient has been or will be subjected to domestic violence, abuse, or neglect by the personal representative, or that treating the personal representative as the patient may endanger the patient and it is not in the best interest of the patient to treat such person as the personal representative.

A denial under these provisions requires a determination by a licensed healthcare professional (such as a physician, physician's assistant, or nurse) based on an assessment of the particular circumstances and current professional medical standards of harm.

If access is denied due to one of these three reasons and you would like to request a review of the denial, please contact the hospital's Privacy Officer.

The checked reason(s) for denial above indicates the section of the HIPAA law that requires or allows this action.

The attached statement describes the basis for the denial further.

_____

_____

_____

_____

If the denial is made based on information to which the patient does not have a right of access as noted above, the hospital will designate a licensed health care professional to act as a reviewing official.

The designated reviewing official will not have been involved in the original decision to deny access. The hospital will provide the patient with written notice of the reviewing official's decision and otherwise carry out the decision in accordance with the requirements of the regulations.

If the individual making the request would like to voice a complaint to the hospital and/or the Office of Civil Rights, they may do so to the following contacts:

Tulare Local Health Care District
~~Jennifer Burcham,~~ Privacy Officer
(559) 685-3409

Office of Civil Rights
The U.S. Department of Health and Human Services
200 Independence Ave., S.W. Rm. 515F HHH Bldg.
Washington, D.C. 20201

(877)696-6775
(202) 619-0257

Descriptive Name:	Patient Right to Access to Medical Records (HIPAA)
Descriptive Type:	Revised
Document Number:	13-9006
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TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Director of Nursing, Medical Records

FROM: Administration

SUBJECT: Storage and Security of Medical Records

PURPOSE:

To ensure that Tulare Regional Medical Center safeguards the integrity, and confidentiality of Protected Health Information by adhering to the applicable laws regarding storage and security of medical records.

POLICY:

Medical records are the property of Tulare Regional Medical Center and are maintained for the benefit of the patients, the medical staff, and Tulare District Hospital. The hospital is responsible for safeguarding both the record and its content against loss, defacement, tampering, or use by unauthorized parties.

PROCEDURE:

Original medical records shall not be removed from the premises of the hospital except by a custodian of records in response to a valid subpoena duces tecum requiring personal production of the original record and personal attendance of the custodian of records, a court order, or pursuant to a valid seizure under state or federal law.

In lieu of the original medical record, a copy shall be produced where possible. If the original medical record must be produced, it shall be personally produced by the duly-authorized custodian of records. The original chart shall be kept in the possession and/or sight of the custodian of records at all times, unless otherwise ordered by a duly-qualified judicial officer.

In cases where a judicial officer orders the original of the medical record held by the court, a request shall be made to the court to substitute a copy for the original. If the original medical record is held by the court, a receipt must be procured from the clerk of the court and filed in the chart folder until return of the original record.

Availability of Medical Records during Working Hours:

When a patient is being treated in the facility, the patient's medical record will be made available to authorized personnel during working hours. Department personnel are responsible for retrieving and signing out the records. After hours, the nursing supervisor is responsible for monitoring and documenting access to medical records.
Medical Records shall not be removed from the record file room without being signed out. A sign-out log is available in the department.

Availability of Medical Records after Hours:

If a medical record is needed when the department is not staffed, the Nursing Supervisor should be notified.

It is the Nursing Supervisor's responsibility to comply with the above policy for removing records. No other personnel shall have access to the Medical Records Department, and the doors of the department are to be kept locked at all times except during working hours.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Storage and Security of Medical Records

Descriptive Type: Revised

Document Number: 13-9025

Attachments: None

Author: Phyllis Gregory/Andrea Carrasco/Ena Menezes

Typist: ~~Melissa Arend~~Andrea Carrasco

Creation Date: 02/01/07

Revision Date: ~~11/25/15~~ 01/26/18

Prev. Dist. Date: 06/23/11

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date: ~~12/24/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : Medical Staff, Medical Imaging and Medical Records

FROM : Administration

SUBJECT: Release of Medical Imaging Reports

In an effort to define an orderly method of releasing x-ray reports following the Radiologist's interpretation, release of medical information and records shall be as follows:

A current list of all Tulare Regional Medical Center (TRMC) physicians shall be kept on file in Medical Imaging and Medical Records. Since these physicians have been deemed by the Medical Staff and the Board of Directors to be ethical and honest, a request from their office will permit the Medical Imaging staff and Medical Records staff to read the body and/or conclusion of a radiographic report over the phone to the physician or office nurse on any requested radiographic examination performed at Tulare District Hospital. However, in order to avoid errors, the preferred alternative would be to have staff fax the report to the physician or nurse.

CONSULTING STAFF: Upon the doctor's request for the information, the hospital person, who is going to read the report to the doctor, shall pull the record and return the call. The hospital staff shall verify with the attending physician that the patient was referred to the requesting doctor. The hospital staff will call the requesting doctor's office and will read or fax the report requested. The referring doctor is encouraged to send copies of pertinent reports to the consultant.

ATTENDING STAFF: If the requesting doctor is the attending physician, the hospital staff will find the report and return the call. The report shall be called or faxed to the attending physician's office.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~04/23/09~~	(13)	Ancillary Services Medical Records: Release of Medical Imaging Reports 13-9030
Approved:		
Medical Executive Comm.: ~~04/08/09~~		
Board of Directors: ~~04/22/09~~		

Descriptive Name: Release of Medical Imaging Reports

Descriptive Type: Revised

Document Number: 13-9030

Attachments: None

Author: Duane Iwamura/Andrea Carrasco/Ena Menezes

Typist: ~~Julie Gresham~~Andrea Carrasco

Creation Date: 02/20/06

Revision Date: 01/26/18

Prev. Dist. Date: 05/25/06

Committee Review and Approval:	Approval Date:	Comments:
Family Practice	~~3/12/2009~~	
MEC	~~04/08/09~~	
Board of Directors	~~04/22/09~~	

Effective Date: ~~04/23/09~~

Forward To: Policy Binders (PBX and Administration) andPost to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff, Clinical Services, Medical Records

FROM: Administration

SUBJECT: Consent for Blood Transfusion

Blood transfusions are deemed complicated procedures and require an informed consent from the patient prior to transfusion. When a patient's condition requires a blood transfusion as ordered by a physician, a Blood Transfusion Consent is signed by the patient or patient's legal guardian. The physicians are responsible for providing information to the patient or family members that will assist the patient and family in making an informed decision regarding blood transfusion. This information must include:

- Risk and benefits of the blood transfusion
- The alternatives to the transfusion
- The possibility of directed donations and autologous transfusions where this is feasible and available

This discussion is documented in the medical record by documentation in the physician progress notes or by use of the blood transfusion order form with notation on the information section of the orders. The patient or appropriate family member signing the Blood Transfusion Consent substantiates verification of the patient receiving the specific information. If consent other than the Blood Transfusion Consent is used for blood transfusion, such as a surgery consent form, then specific information as presented above (risks and benefits, etc.) must appear either on the consent or in the physician progress notes.

The Paul Gann Blood Safety Act imposes specific obligations on physicians to provide information concerning autologous blood and directed or non-directed homologous blood from volunteers. As well Health and Safety Code Section 1645 requires that patients be given the brochure, "If You Need Blood: A Patient's Guide to Blood Transfusions" whenever there is a reasonable possibility that a transfusion will be recommended. This brochure is given to the patient or responsible family member prior to the consent being signed. Nursing staff may obtain the patient's signature on the consent

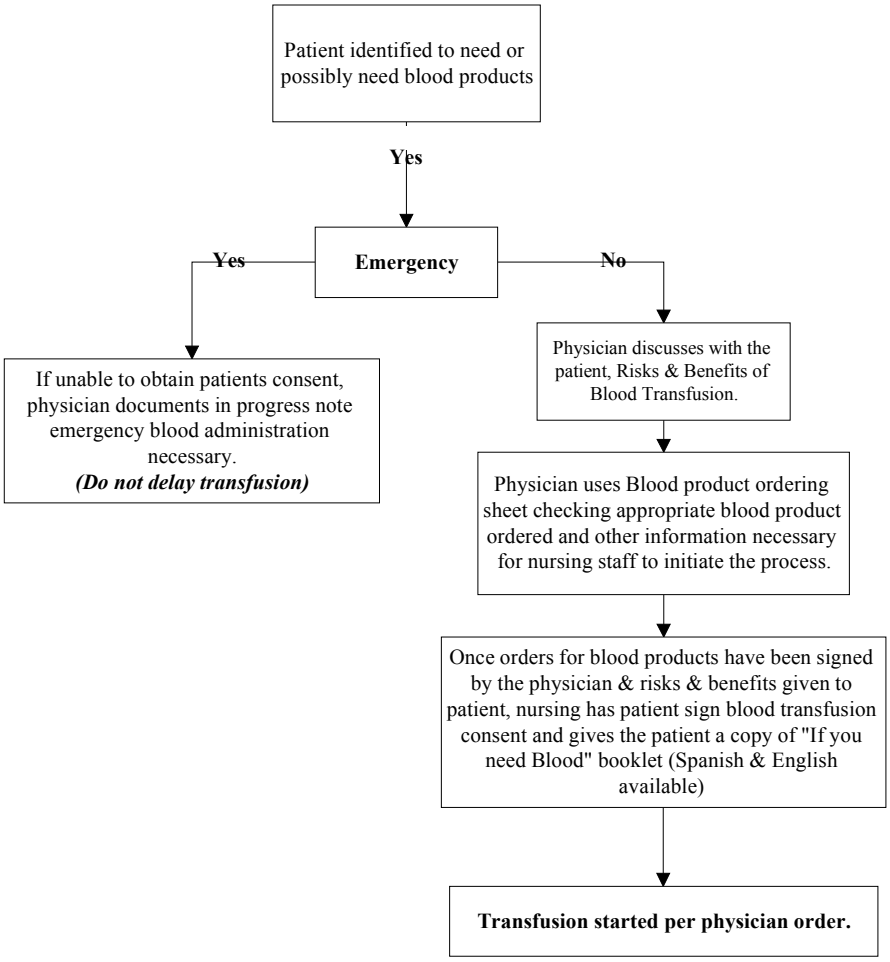
once the physician has given the patient the risks, benefits and alternatives regarding blood transfusions.

Whenever the standardized information and brochure (sheet) is not given to the patient prior to a transfusion because of a medical contraindication or a life-threatening emergency, the physician shall document the circumstances in the patient's medical record at the earliest opportunity possible. Transfusion orders because of a life-threatening, emergency situation must not be delayed.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

BLOOD PRODUCTS ORDERING & ADMINISTRATION FLOW CHART



CONSENT TO BLOOD TRANSFUSION

Your signature below indicates that:

1. You have received a copy of the brochure *"If You Need Blood: A Patient's Guide To Blood Transfusions."*
2. You have received information concerning the risks and benefits of blood transfusion and of any alternative therapies.
3. You have had the opportunity to discuss this matter with your physician, including pre-donation
4. Subject to any special instructions listed below, you consent to such blood transfusions as your physician may order in connection with the operation or procedure described in this consent form.

Special Instructions:_____

_____

_____

_____

[Describe her any specific instruction for patient's blood transfusion, e.g., pre-donation, directed donation, etc.]

_____ _____
_____a.m./p.m.
Signature [patient/parent/conservator/guardian] ***Date*** ***Time***

_____ _____
Relationship [if signed by other than patient] *Witness*

CONSENTIMIENTO PARA TRANSFUSION DE SANGRE

Su firma al calce indica que:

1. Usted ha recibido una copia del folleto "Si Usted Necesita Sangre: Guia para el Paciente Respecto a las Transfusiones de Sangre".
2. Usted ha recibido informaci`on respecto a los riesgos y beneficios de la transfusi`on de sangre y de terapias alternativas
3. Usted ha tenido la oportunidad de conversar sobre este asunto consu m`edico, incluyendo la donaci`on por adelantado.
4. Sujeto a las instrucciones especiales enumeradas a continuaci`on, usted consiente a dichas transfusiones de sangre seg`un lo indique su m`edico, en relaci`on a la operaci`on o procedimiento que se describe en este formulario de consentimiento.

Instrucciones especiales:

_____

_____

_____

[Describa aqu`I cualquier instrucci`on espec`ifica para la transfusi`on de sangre del paciente, por ejemplo, la donaci`on por adelantado, donaci`on dirigida,, etc.]

_____ _____
_____a.m./p.m.
Firma (paciente/padre/madre/conservador/tutor) *Fecha* *Hora*

_____ _____
En caso de firmarse por una persona que no sea el paciente, indique la relaci`on *Testigo [Witness]*

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

REFUSAL TO PERMIT BLOOD TRANSFUSION

I request that no blood or blood derivatives be administered to _____
Name of Patient
during this hospitalization. I hereby release the hospital, its personnel, the attending physician, and any other person participating in my care from any responsibility whatsoever for unfavorable reactions or any untoward results due to my refusal to permit the use of blood or its derivatives. The possible risks and consequences of such refusal on my part have been fully explained to me by my attending physician and I fully understand that such risks and consequences may occur as a result of my refusal.

_____ _____ _____a.m./p.m.
Signature (patient/parent/conservator/guardian) *Date* *Time*

_____ _____
Relationship (if signed by other than patient) *Witness*

DOCUMENTO PARA NO PERMITIR LA TRANSFUSION DE SANGRE

Solicito que no se administre sangre ni ning`un derivado de sangre a _____
Nombre del paciente
durante esta estad`ia en el hospital. Por medio de la presente, exonero al hospital, su personal, al m`edico del caso u a cualquier otre persona que participe en mi atenci`on de cualquier responsabilidad en cuanto a reacciones desfavorables o cualquier resultado adverso debido al de mi parte de permitir el uso de sangre o sus derivados. Los riesgos y las consecuencias posibles de este de mi parte me han sido explicados totalmente por el m`edico de mi caso y comprendo totalmente que los riesgos y consecuencias mencionados pueden ocurrir como resultado de mi.

_____ _____ _____a.m./p.m.
Firma (paciente/padre/madre/conservador/tutor) *Fecha* *Hora*

_____ _____
En caso de firmarse por una persona que no sea el paciente, indique la relaci`on *Testigo [Witness]*

Descriptive Name: Consent for Blood Transfusion

Descriptive Type: Revised

Document Number: 13-9031

Attachments: Yes - Consent forms

Author: Angie Graziano

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 04/10/06

Revision Date: 01/17/18

Prev. Dist. Date: 05/25/06

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~10/27/10~~	
MEC	~~11/10/10~~	
Board of Directors	~~11/16/10~~	

Effective Date: ~~11/17/10~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees

FROM: Administration

SUBJECT: Access to Health Information Management (HIM) Department

I. POLICY:

It is the policy of Health Information Management (HIM) to ensure the confidentiality of all medical records and physician profiles and activities.

II. PROCEDURE:

A. HIM is considered a secure area. Activity areas of the department (the doctors incomplete area, analysis and correspondence, and coding) are OFF- LIMITS to everyone except HIM employees or persons who have permission to access medical records (i.e., for review, audit, core measures, and quality assurance). Other personnel who are in the department to perform a specific function (i.e., repair may have access to the area in question after checking with supervision personnel.

B. Personnel from other departments needing to pick up records or reports for continuing care will be seated in the chairs at the front desk reception area if the record is not ready. Records and medical information are not accessible by Tulare Local Health Care District employees who are not wearing their identification badge.

C. Patients requesting medical information are limited to access to the reception area.

D. Any other person may be referred to supervisory personnel and questioned regarding the purpose of their visit. If a visitor becomes hostile and is unwilling to leave when asked, the Security Department shall be contacted for assistance.

E. Visits from friends, relatives, or former employees shall occur outside the department so as not to disturb fellow employees.

F. Outside doors to the department will be secured by keypad locks.

G. The following personnel and/or their designated representatives have access to the off-site clinic (Hillman) where confidential information is stored. These personnel need access for business reasons only and are held to the same confidentiality agreement as the HIM staff.

1. Hillman Clinic Health Information Management Staff

2. Security that will be responsible to escort staff after hours for chart retrieval upon request.

III. REFERENCES:

Accreditations Standards:
Legal Reference: 45 CFR Parts 160 and 164; 22 CCR & 56, 10 et. Seq.
CHA Consent Manuel, current edition, The California Hospital Association
Records Retention Guide, current edition and Title 22
Medicare COP

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Access to Health Information Management (HIM) Department
Descriptive Type:	Revised Policy
Document Number:	13-9034
Attachments:	None
Author:	Phyllis Gregory/Andrea Carrasco/Ena Menezes
Typist:	~~Melissa Arend~~Andrea Carrasco
Creation Date:	09/09/09
Revision Date:	~~11/30/15~~ 01/26/18
Previous Dist. Date:	12/17/09

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Privacy and Security Incident Management

I. PURPOSE:

The purpose of this policy is to define a process to address privacy and security-related complaints received from individuals—patients, their family members, staff and other sources—concerning the processing and protection of their Protected Health Information ("PHI"). This policy will be carried out in accordance with the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations, 45 CFR Parts 160 and 164, as they are amended from time to time (collectively "HIPAA").

II. POLICY:

It is Tulare Regional Medical Center's policy to protect the privacy of PHI and ePHI in compliance with applicable law, as well as with the District's policies and business practices. In accordance with such law, policies and business practices, it is the District's policy that all complaints related to privacy will be investigated, and resolved, in a timely manner. It is the District's policy to communicate with Individuals who report privacy-related complaints, as required by this Policy, and to help ensure that such individuals understand the District's privacy complaint handling procedure and are informed as to the status of the investigation of the complaint. Complaints that have not been resolved internally may, at the complainant's option, be forwarded to the Dispute Resolution Process. Through reporting and analysis, the District will track and trend privacy complaints to identify areas requiring systemic interventions to ensure future compliance.

III. PROCEDURE:

A. Privacy and/or Security related complaints should be made via the HIPAA Hotline.

B. The HIPAA office will be responsible for generating and issuing a report to Compliance Officer on a quarterly basis, to use to identify trends and potential areas requiring corrective action. The HIPAA Officer is also

responsible for tracking the status of all unresolved complaints and outstanding corrective action items on a monthly basis.

C. The Privacy and Security Officer is responsible for reviewing all privacy and/or security-related complaints, for performing or coordinating the investigation and resolution of complaints and for handling all unresolved complaints. The Privacy or Security Officer will present unresolved complaints to the appropriate venue for resolution. The Privacy or Security Officer will be responsible for moving unresolved complaints into the Dispute Resolution process. Both Officers are responsible for completing the Investigation Report to reflect the disposition of complaints.

D. Both Officers are responsible for reviewing reports regarding complaint trends, status of complaints and corrective actions, and reporting identified issues to the compliance committee.

E. Legal Counsel

1. Both Officers will seek advice from legal counsel as necessary to evaluate potential resolutions to complaints and to receive advice on legal ramifications.

2. All privacy or security-related complaints to enter the Dispute Resolution Process will be forwarded to legal counsel.

3. All Departments that Handle or Collect PHI.

a. It is the responsibility of these departments to forward any security or privacy-related complaints received to the Privacy or Security Officer via the HIPAA hotline.

F. Intake of a Privacy or Security Complaint

1. The HIPAA office will process all privacy-related complaints. The Security Officer will process all security-related complaints. The appropriate Officer will contact the complainant by telephone, if the Individual has provided his or her telephone number or otherwise by e-mail or letter, within twenty-four (24) hours of receipt of the complaint and obtain from the complainant any additional information needed.

2. For complaints coming in via the HIPAA hotline, the HIPAA office will initiate an incident file.

3. The HIPAA Office will also inform the Complainant that the Complaint Handling Process has been initiated and that the Complainant will be contacted by someone responsible for investigating the complaint.

G. Investigation and Attempted Resolution of a Complaint

1. The appropriate Officer/designee will contact the Complainant to obtain any additional information needed to complete the Incident Report and to assist in the investigation.

2. As part of the investigation, the appropriate Officer/designee will identify and interview members of the District's staff in possession of relevant information to develop a record of the facts and circumstances surrounding the complaint. The officer will work closely with Human Resources in this process. The Privacy or Security Officer/designee will document all findings and add those documents to the complaint file. The Privacy or Security Officer will make every effort to assure that the investigation is completed in a timely manner.

3. Once the Privacy or Security Officer or his/her designee has completed all fact-finding, he or she will develop recommended steps for resolution of the complaint.

4. The Officer will notify the Complainant's either by phone or certified mail that the complaint has been investigated and either noted to be unfounded or resolved. Specific details of the investigation and any disciplinary actions, if applicable will not be shared with the Complainant.

5. Upon successful disposition of the complaint, the Privacy or Security Officer/designee will update the Incident database to reflect closure of the complaint.

6. If the Complainant does not accept the resolution or the matter has not been concluded in a reasonable period of time for other reasons, the Privacy or Security Officer will present the unresolved complaint to the Chief Compliance Officer and/or Compliance Committee for further review. The Chief Compliance Officer and/or Compliance Committee will consider the facts and circumstances and propose a resolution.

7. The Privacy or Security Officer will contact the Complainant and inform him or her of the resolution. If the Complainant is still not satisfied, the Complainant will be referred to Administration and/or Legal Counsel.

8. In the event that resolution of a privacy-related complaint involves disciplinary actions against a member of the District's workforce, such actions will be taken in accordance with the District's policies. In the event the Privacy/Security Officer determines a violation has occurred which has resulted in a harmful effect, the Privacy Officer will take steps to mitigate such harmful effect pursuant to the Policy on Mitigation.

H. Complaint Closure and Documentation

1. The Privacy or Security Officer, as applicable, will document the disposition of all complaints.

2. The Privacy or Security Officer or designee will review the complaint file to ensure the file contains all information. The Privacy or Security Officer or designee will maintain complaint files for six (6) years from the date of disposition.

I. Corrective Action

1. Upon closure of a complaint, the Privacy or Security Officer will, on a monthly basis, check the status of any required corrective actions for all complaints that have been processed. Upon completion of a corrective action Privacy Officer will update the complaint file to reflect completion of the corrective action.

2. The HIPAA Office will run a monthly report detailing the status of outstanding corrective action items, as well as quarterly basis to identify trends.

3. The Privacy or Security Officer will present potential trends and potential corrective action items to the Compliance Committee for advice and resolution.

J. Documentation Retention

1. All documents required under this procedure will be retained, at a minimum, for six (6) years from the date of its creation or the date when it was last effective, whichever is the latest date.

2. No documents will be destroyed before consultation with the Privacy Officer and/or Chief Compliance Officer.

Note: If you have questions regarding this policy, please contact the HIPAA office. ~~at x3494.~~ These documents shall be retained for 7 years.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Privacy and Security Incident Management

Descriptive Type: ~~New Policy~~Revised

Document Number: 13-9035

Attachments: None

Author: Filomena Santos~~LuAnn Perry~~/Andrea Carrasco/Ena Menezes

Typist: ~~Julie Gresham~~Andrea Carrasco

Creation Date: 09/09/09

Revision Date: 01/31/18

Previous Dist. Date: ~~None~~

Committee Review:	Approval Date:	Comments:
Board of Directors	~~01/26/11~~	

Effective Date: ~~01/27/11~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Compliance with HIPAA Regulations

I. POLICY:

The specific form of Tulare Regional Medical Center (TRMC) Health Insurance Portability and Accountability Act (HIPAA) compliance efforts will compliment TRMC Health Board Policy of HIPAA implementation.

II. PURPOSE:

A. This policy re-affirms Tulare Regional Medical Center commitment to achieving compliance with the Electronic Data Interchange (Transactions & Code Sets), Privacy and Security regulations of HIPAA.

B. Tulare Regional Medical Center's HIPAA compliance will:

1. Operate in addition to or in conjunction with applicable state law;

2. Ensure patient rights as defined under HIPAA;

3. Monitor mechanisms to ensure HIPAA-related issues are reviewed and addressed and encourage members of the workforce, patients, providers, business associates, vendors and others to report actual or potential HIPAA violations to the Privacy Officer;

4. Educate all members of the workforce on HIPAA and continue ongoing education modalities;

5. Ensure systems for monitoring compliance and correcting any violations of HIPAA by the use of effective response initiatives and enforcement tools;

6. Report periodically, but not less than annually, to the Compliance Committee

Note: If you have questions regarding this policy, please contact the HIPAA office. ~~at x3445.~~ These documents shall be retained for 7 years.

III. REFERENES:

Legal Reference: 45 CFR Parts 160 and 164; 22 CCR 56.10 et. seq.
Literary Reference: TRMC Employee Handbook

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Compliance with HIPAA Regulations
Descriptive Type:	Revised Policy
Document Number:	13-9036
Attachments:	None
Author:	Phyllis Gregory/ Andrea Carrasco/ Ena Menezes
Typist:	Melissa Arend
Creation Date:	07/07/10
Revision Date:	~~11/30/15~~ 01/31/18
Previous Dist. Date:	01/27/11

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders – (PBX and Administration)and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Fax Policy for Transmitting Protected Health Information

I. POLICY:

A. Fax machines shall be located in secure locations not accessible by the public or other unauthorized individuals.

B. Protected health information (PHI) shall be faxed only when mail delivered copies will not meet the needs of immediate patient care.

C. Fax requests for protected health information to support patient care shall be answered within 30 minutes or less. The requesting party shall be notified of any delays greater than one hour in responding to the request for faxed health information, by the vendor staff.

D. Routine disclosure of protected health information from insurance companies, attorneys or other legitimate users shall be made through regular mail or delivery service.

E. A properly completed and signed authorization should be obtained prior to the release of patient information via fax transmission, with the exception of requests for treatment, payment and hospital operations (TPO).

F. The Fax Cover Sheet that prominently displays a 'Confidentiality Notice' shall always be used when faxing protected health information.

G. The fax number shall be verified prior to faxing protected health information by read back verification to the requestor before ending the phone call.

H. Check the fax confirmation slip to ensure that the confidential patient information went to the proper destination. If there has been an error,

contact the incorrect recipient immediately and request the return of the fax.

I. Confirm that the fax was delivered to the right number. If the verification of receipt is not received, please contact the recipient immediately to verify receipt.

J. Maintain a copy of the fax cover sheet along with the request for information in the patient's medical record.

K. For any misdirected fax, you must notify the HIPAA Privacy Officer and request that the recipient return the information by mail or courier as soon as possible.

L. Results of test, transcribed reports, physician orders, etc. may be faxed internally to expedite patient care services.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Fax Policy for Transmitting Protected Health Information
Descriptive Type:	Revised Policy
Document Number:	13-9037
Attachments:	None
Author:	Phyllis Gregory/Andrea Carrasco/Ena Menezes
Typist:	Melissa Arend
Creation Date:	09/09/10
Revision Date:	~~11/30/15~~ 01/26/18
Previous Dist. Date:	01/27/11

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Identity Theft Program

I. PURPOSE:

A. To provide process and assign roles and responsibilities for implementation of the Tulare Regional Medical Center Identity Theft Prevention Program.

B. The Program requires TRMC to establish procedures that identify, detect and respond to patterns, practices or specific activities that could indicate a potential identity theft incident. The program consists of all departments of Tulare Regional Medical Center's policies for detection, prevention and response to potential theft or misuse of patient information and other demographic and financial information.

C. This policy is intended to comply with the Identity Theft Red Flag Rules that were promulgated pursuant to the Fair and Accurate Credit Transaction Act of 2003.

II. POLICY:

A. TRMC will establish written procedures for identifying, detecting, preventing, and mitigating theft or misuse of demographic and financial information. After the patient has been pre-screened, these procedures will be implemented throughout the organization:

1. Verification of patient identity.

2. Investigation, reporting and follow-up on known or suspected identity theft incidents.

3. Effective incident response and mitigation measures that prevent harm to patients and allow compliance with State and Federal regulations for HIPAA and security incident reporting.

4. Staff training on policy and procedure requirements and the consequences of noncompliance.

5. Safeguards to secure demographic and financial information including minimum necessary access limitations.

6. Documentation retention and Program update requirements.

III. PROCEDURES:

A Verifying the identity of patients:

1. Acceptable documentation of identity is required from each adult patient, 18 years and older or emancipated minor at the time care is requested.

2. Picture ID is not required for unemancipated minors. The registrar will verify the identity of the guarantor, if present (e.g. photo ID) as well as request the guarantor to present his or her insurance card showing coverage of the minor.

3. For all elective inpatient and outpatient services authenticated patient identification is preferred before treatment is provided. However, treatment shall not be delayed or denied if identification cannot be obtained.

4. If there is reason to believe that the patient presenting may be an undocumented person, the registrar or financial counselor may begin the process to qualify the patient for any government sponsored health care program.

5. All departments subject to the Emergency Medical Treatment and Active Labor Act (“EMTALA”) shall provide the patient with medical screening and triage (consistent with EMTALA) regardless of whether the patient’s identification can be confirmed.

B. Patient Identity Verification during the Registration Process

1. When a new patient calls to request an appointment or presents for a service, the patient will be asked to provide one or more of the following items:

a. Driver’s license or other acceptable photo ID (Refer to the list of acceptable photo IDs in Addendum A).

b. If the patient questions the need to provide proper identification, the registrar will reassure the patient of our need to keep them safe while they are in our care.

c. If the photo ID does not show the patient's current address, additional documentation will be requested to verify his or her current address (e.g., utility bills or other correspondence showing residence).

d. Homeless patients will be asked which homeless shelter(s) they usually stay at.

e. Current insurance card if paying by insurance. If the patient is uninsured, the patient should be referred to financial counseling.

f. Completed information packet if mailed out by the provider to the patient before the scheduled appointment.

2. The Photo ID will be scanned into the information system.

3. The insurance card will be validated against the identity information provided and scanned into the information system.

4. The document and other information provided by the patient will be reviewed for authenticity and to confirm the identification of the patient.

5. Authentication of Documents and Other Information. The person who reviews the documentation should be alert / aware of the following:

a. Appearance of alteration or forgery.

b. Patient presenting does not resemble the patient photos/identification from previous visit.

c. The photograph or physical description shown on an identification document does not reasonably match the patient's appearance.

d. Other information on the documentation is inconsistent with information provided by the patient (e.g., address, date of birth, etc.).

6. The staff will attempt to obtain positive identification at multiple points during an emergency room encounter in concordance with EMTALA regulations.

C. Concerns about the Validity of Patient ID during the Registration process

1. If a patient presents with no documentation:

   a. To the extent feasible, the patient will be provided an opportunity to obtain the necessary documentation (e.g., calls to get wallet from home, etc.)

   b. If documentation cannot be provided and the patient is not known to the provider, staff will notify their management team who will ensure there are continued attempts to obtain appropriate documentation throughout the patient's stay.

2. If documentation appears to be valid, but there are discrepancies with existing information (e.g., name change), the registrar will ask the patient for an explanation and note the explanation in the account.

3. The registrar may also contact the physician's office to validate the presenting patient's identity.

4. If a reasonable response is provided (e.g., name change due to marriage), the registration process will be completed.

5. If a reasonable response is NOT provided and there is a high likelihood that the patient is not who they say they are, copies of the documentation will be made and the patient shall be registered per established protocols.

6. The registrar will inform the patient that a member of our staff will follow up with them to finalize the registration process.

7. After the patient is registered, the registrar will notify his/her supervisor of the concern and provide the relevant information.

8. The manager will place a flag (See Appendix C) under Patient Accounting menu "Business Office 1" "Account Inquiry" alerting staff to a possible identity theft situation.

9. If the presenting patient is suspected of falsely claiming to be an existing patient, the medical records of each patient will remain

separated (via pseudonym registration) during the investigation period.

10. The department head or his/her designee will notify the HIPAA Officer and work with the HIPAA Officer to investigate the matter.

11. The HIPAA Officer will notify Patient Financial Services to place a "hold" on the patient's account until the investigation is complete (e.g., not bill the insurance company or patient).

12. At the conclusion of the investigation, the HIPAA Officer will inform Patient Financial Services, HIM, and other departments as necessary on the disposition of the matter and appropriate action (e.g., finalize the registration, create new patient record, place an alert on the patient's account, etc.).

D. Patients Presenting after Services are Rendered:

1. When a patient asserts that he/she received a bill for services he/she did not receive, staff will report the matter to their manager and the matter will be submitted to the HIPAA Officer for further investigation.

E. Staff in departments who perform registration, medical record and/or billing functions or who interact with the patient during a clinical care event should be aware that the following events could indicate a potential identity theft incident and bring the event to the attention of appropriate management who will notify the HIPAA Officer.

1. The presenting patient is recognized by staff as having received treatment under another name, social security number or date of birth.

2. The presenting patient uses the name and other ID of a patient who is known to staff but he or she does not appear to be the patient.

3. The presenting patient or his/her visitors make remarks that lead staff to believe that the patient may not be who he or she claims to be.

4. Records showing medical treatment that is inconsistent with a medical history as reported by the patient.

5. The presenting patient has been identified as a possible identity thief by another patient, management, external financial institution, law enforcement authority, or other person.

6. Physician orders are in a different name that the presenting patient gives.

7. Patient asserts that they did not receive the service for which they were billed.

8. The patient's registration record has a "PP" or "XX" flag.

E. Identity Theft Reporting:

1. Any time an identity theft occurrence has been confirmed; the incident will be documented and reported by the HIPAA Official or his/her designee for required statistical reporting purposes. (See Appendix B for roles and responsibilities)

IV. REFERENCES:

Legal: 16 CFR Part 681, "Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003"

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Appendix A

Description	Requirements
Driver's License	Any state with photograph – current, or expired not more than 6 months.
Driver's License, Learner's Permit	Any state with photograph – current, or expired not more than 6 months.
State – issued I.D. Card	Any state with photograph – current, or expired not more than 6 months.
Bureau of Citizenship and Immigration Services (BCIS) Documents	Must be original and valid.
Certificate of Naturalization	N-550, N570, or N578
Certificate of US Citizen	N560, N561, or N645
US Military ID Card	Must be valid with photography; issued to military personnel only.
US Passport	Valid: unexpired
Valid Military Dependent Identification	Unexpired with photograph
Foreign Passport with Visa	Passport must be in English or translated by an embassy. Issued by the INS without expired visa and must be valid for six months or more. Status codes J1 or J2, F1 or F2, G4, or code I.
Unexpired Resident Alien Card	I551 Green Card
Permanent Resident Card	I551
Unexpired US Citizen ID Card	I197, I179
Unexpired Diplomat Certificate with Diplomat Identification Card	Issued by the US Dept. of State
Employee Work Identification Card	Photograph and Name
Student Identification Card	Photograph and Name

Appendix B

Roles and Responsibilities in departments that perform Registration, Medical Record and/Or Billing functions OR caregivers who become aware of identity issues:

Role / Responsibility	Staff	Caregivers	Managers	HIPAA Officer
Detection of Identity Theft	X	X	X	X
Positively Identify Patients	X	X	X	
Reporting Potential Identity Theft Incidents to Managers	X	X		
Flagging Records of Patients Involved in Potential and Confirmed Cases of Identity Theft			X	
Reporting Potential Incidents to the HIPAA Officer			X	
Reporting Incidents to Tulare Regional Senior Leadership				X

Detection of Identity Theft: staff become aware there are discrepancies between what the patient says and the documentation presented. (i.e., signatures don't match driver's license pictures don't match, etc.)

Positively Identify Patients: patient self discloses to caregiver or other staff member they are not the person for whom the documentation was presented (i.e., states is cousin of person on ID to the nurse or Social worker, etc.)

Reporting potential identity theft incidents to manager: Any department manager who receives a report of potential identity theft has the duty and responsibility to report such incidents immediately to the HIPAA Officer via the Incident Reporting system.

Upon completion of the investigation, the HIPAA Officer will notify selected individuals and compile a report for the Senior Leadership.

Descriptive Name:	Identity Theft Program
Descriptive Type:	Revised Policy
Document Number:	13-9038
Attachments:	None
Author:	Phyllis Gregory~~/, Curtis Haley~~Filomena Santos/ Andrea Carrasco/ Ena Menezes
Typist:	~~Melissa Arend~~Andrea Carrasco
Creation Date:	07/07/10
Revision Date:	~~12/02/15~~ 01/31/18
Previous Dist. Date:	01/27/11

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders (PBX and Administration)and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Medical Record Content

I. POLICY:

A. Tulare Regional Medical Center shall ensure that the medical record shall contain sufficient information to:

1. Identify the patient

2. Support the diagnosis/condition

3. Justify the care, treatment and services

4. Accurately document patient's progress and response to medications and services.

5. Promote continuity of care among providers

B. All entries in the medical record shall be legible, dated, timed and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided. Additionally, the time and date of each entry (orders, reports, notes, etc.) must be accurately documented.

II. PROCEDURE:

A. The Admitting Department is responsible for collecting sufficient information to identify the patient. The information is documented on the face sheet, which is a permanent part of the patient's record. Sufficient information includes, but may not be limited to:

1. Patient's name

2. Gender

3. Primary language spoken

4. Communication needs

5. Address

6. Date of birth

7. Authorized representatives (if any)

8. Legal status of patients receiving behavioral healthcare services

B. All entries in the medical record (information/documentation regarding evaluations interventions, care provided, services, care plans, discharge plans, and the patient's response to those activities, laboratory reports, test results, consults, assessments radiology reports, dictated notes, etc. must be promptly filed in the patients' medical record in order to be available to the physician and other care givers. Examples of entries and documentation are as follows:

1. Allergies

2. Emergency care, treatment and services received by the patient before his/her arrival at the hospital shall be documented.

3. The legal status of patients who are receiving behavioral healthcare services shall be documented in the patient's medical record.

4. A comprehensive history and physical (H&P) examination shall be completed within 24 hours of admission to inpatient services by the appropriate practitioner privileged to perform H&Ps. The H&P shall be obtained from the patient when possible. Refer to policy #13-9018 Recording of History of Physical for required content.

5. There is evidence of informed consent in the patient's medical record.

6. There is evidence of known advance directives in the patient's medical record.

7 Clinical observations are made daily in the progress notes by the physician. Other persons making observations shall report on designated forms. These progress notes give a pertinent chronological report of the patient's course in the hospital and

reflect any change in condition, the results of treatment and plan of care revisions when indicated.

8. Consultation reports contain a written or dictated opinion by the consultant that reflects an actual examination of the patient, when applicable, and the patient's medical record.

9. Nurses' notes and entries by non-physicians contain pertinent and meaningful information and observations. This information is documented in the medical record.

10. Opinions requiring medical judgment are written and authenticated only by the medical staff members in the progress notes or on consultation reports.

11. All reports of diagnostic and therapeutic procedures, tests and their results are documented and authenticated in the medical record.

12. All medications ordered are documented in the medical record.

13. Medication administration. Refer to policy #13-5063 Medication Administration and Documentation.

14 For those patients who are receiving continuing outpatient (ambulatory) services, a list of the following will be made upon initial presentation, if possible; however, no later than the third visit (when more complete information can be listed due to continuing care):

    a. Known diagnoses (significant and secondary)

    b. Known or observed conditions

    c. Prior operative and invasive procedures

    d. Drug allergies

    e. Known adverse drug reactions

15. Medication:

    a. Current prescriptions

    b. Over-the-counter medications

c. Herbal supplements

16. Operative reports. Refer policy #13-9027 Operative Report Requirements.

17. Reports of Pathology and Clinical Laboratory examinations, Imaging/Radiology, Anesthesia and any other diagnostic or therapeutic procedure are filed in the medical record within 24 hours of completion.

18 Patient and family education is documented by all disciplines, as applicable, in the patient's medical record.

19. Communication with the patient, verbally or via e-mail or telephone, is documented in the patient's medical record.

20. All patient-generated information is documented (i.e., information entered into the record over the Internet or various forms of electronic media from laboratory or other diagnostic avenues, pre-visit clinical data or other types of information).

21. The discharge summary or final summary. Refer to policy #13-9026 Discharge Summaries.

22 A copy of the discharge instructions given to the patient is filed in the medical record.

23 The medical record must be completed within 14 days post patient discharge from the facility.

III. REFERENCES:

Centers for Medicare & Medicaid Services 42 CFR §482.24, NIAHO/DNV Accreditation Requirements

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Medical Record Content
Descriptive Type:	Revised Policy
Document Number:	13-9039
Attachments:	None
Author:	Phyllis Gregory/ Andrea Carrasco/ Ena Menezes
Typist:	~~Melissa Arend~~Andrea Carrasco
Creation Date:	07/07/10
Revision Date:	~~11/30/15~~01/31/18
Previous Dist. Date:	01/27/11

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Mitigating Violations of HIPAA and Privacy Related Policies and Procedures

I. PURPOSE:

The purpose of this policy is to require Tulare Regional Medical Center provide for mitigation, to the extent practicable, of harmful effects that are known to it, which arise out of the Use and Disclosure of Protected Health Information ("PHI").

II. POLICY:

A. Tulare Regional Medical Center will mitigate, to the extent practicable, any harmful effects that are known to it, which arise out of the Use or Disclosure of Protected Health Information ("PHI") in violation of Tulare Regional' privacy-related policies or in violation of HIPAA, by either members of its Workforce or its Business Associates.

B. Reports of Suspected Violations:

1. All reports of suspected violations of Tulare Regional privacy-related policies or of HIPAA requirements by a Workforce Member or a Business Associate will be forwarded immediately to the Privacy Officer ~~(685-3494)~~ and referred as appropriate to Chief Compliance Officer.

2. The Privacy or Security Official will conduct an investigation of the reported violation and, as part of that investigation, will document the violation and any resulting harmful effects of which he or she knows.

3. The Privacy or Security Official, in consultation with Chief Compliance Officer will take steps, as reasonably practicable, to mitigate the harmful effects of such violation. Such steps may include, but are not limited to, suspending any further use or disclosure of PHI that may

be in violation of Tulare Regional privacy-related policies or of HIPAA, sanctions against Workforce Members in accordance with the Policy on Disciplinary Actions for Privacy-Related Violations and termination of Business Associate Arrangements in accordance with the Policy on Business Associate Arrangements.

4. The Privacy or Security Official will document all actions taken under this policy.

C. Review of Complaints and Audits:

1. The Privacy or Security Official will review all privacy or security-related complaints to identify potential violations for which Tulare Regional could take steps to mitigate their harmful effects.

2. The Privacy or Security Official will review all internal audit reports to identify potential violations for which Tulare Regional could take steps to mitigate their harmful effects.

3. The Privacy or Security Official will take steps, as reasonably practicable, which may include, but not be limited to, the actions identified above, to mitigate any harmful effects of violations discovered pursuant to this section.

D. Documentation Retention:

1. No documents will be destroyed before consultation with the Privacy or Security Official and/or legal counsel.

Note: If you have questions regarding this policy, please contact the HIPAA officer. ~~at x3494.~~ These documents shall be retained for 7 years.

IV. Legal Reference:

Centers for Medicare and Medicaid 45 CFR Parts 160 and 164; 22 CCR § 56.10 et. seq.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Mitigating Violations of HIPAA and Privacy Related Policies and Procedures
Descriptive Type:	Revised Policy
Document Number:	13-9040
Attachments:	None
Author:	Phyllis Gregory/Andrea Carrasco/Ena Menezes
Typist:	~~Melissa Arend~~Andrea Carrasco
Creation Date:	07/07/10
Revision Date:	~~11/30/15~~ 01/31/18
Prev. Dist. Date:	01/27/11

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Medical Staff

FROM: Administration

SUBJECT: Lost or Missing Patient Records

I. POLICY:

Upon discovery of lost or missing record, the Health Information Management Department (HIM) staff will take all reasonable steps to recover lost patient information.

II. PROCEDURE:

A. Health Information Management personnel responsible for record collection, assembly and/or analysis will notify the HIM Director, Manager or Supervisor of lost or missing records after reasonable efforts to recover record with the originating department (s).

B. The HIM Department Director, Manager or Supervisor will immediately notify the Risk Manager of lost or missing records upon discovery of loss and complete an online incident report~~d~~ Quality Review Report (QRR).

C. HIM Department will initiate "Missing Record Recovery Effort" process as noted below:

1. Upon inventory of record components missing, the HIM staff will contact physician(s) and ancillary departments involved in care to recreate missing documentation components as soon as possible upon discovery of loss.

2. Replica documentation will be placed in the patient's medical record along with a completed "Declaration of Replica of Original Record" and "Missing Health Record Recovery Efforts" form.

II. <u>Procedure for ER Chart Routing Change</u>

A. Monday – Friday:

1. The Emergency Department patient charts will be reconciled by the night shift ED Tech for all patient visits from 00:00 am to 23:59 pm of each day. The ED Staff will put them in alphabetical order

2. Once the ED charts have been reconcil~~iat~~ed, he/she will place them on the back file cabinet for ED Charge Capture tech to pick up. He/she will charge the charts and do reconciliation.

3. ED Charge Capture will route the ED charts to Medical Records and give to the ED Coder along with the reconciliation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

This record is a replica of the original. The original has been reconstructed to the extent possible with the efforts noted below in recovery efforts. For purposes of hospital business, it is considered to be an entire and complete record and copies will be replaced with the original upon recovery.

This form is considered part of the medical record and is to be released with any record requests when missing portions or those unable to be replicated are requested.

Missing Health Record Recovery Efforts

Date of loss discovery: _____Originating Unit: _____

Originating Unit Supervisor: _____

Originating Unit Supervisor contacted and good-faith recovery effort request made:

Yes_____ No_____ Date: _____

Dates of record reconstruction: _____

List documentation reconstructed:

_____

Document Source

_____

Document Source

_____

Document Source

_____

Document Source

_____

Document Source

_____

Document Source

_____

Document Source

List of known missing record portions remaining:

_____

_____

_____

_____

Descriptive Name:	Lost or Missing Patient Records
Descriptive Type:	Revised Policy
Document Number:	13-9041
Attachments:	None
Author:	Phyllis Gregory/Andrea Carrasco/Ena Menezes
Typist:	~~Melissa Arend~~Andrea Carrasco
Creation Date:	07/07/10
Revision Date:	~~12/02/15~~ 01/31/18
Previous Dist. Date:	01/27/11

Committee Review:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Environmental Services~~Housekeeping~~, Nursing Services, Emergency Services, Lab, MI, Respiratory Care~~RT~~, Pharmacy, Education.

FROM: Administration

SUBJECT: Hospital Supplied Scrub Suits and Wearing Apparel

The hospital shall supply designated departments, via Administration's approval, with Wearing Apparel such as: scrub suits, lab coats and smocks.

This apparel is supplied by our outside laundry company. All apparel is considered hospital property and must not leave the hospital grounds.

Any alterations to scrub suits or wearing apparel, ie: style changes, color changes, embroidery, or patches, must have the prior approval of Administration.

The following limitations and exceptions must be followed to insure an adequate supply of apparel:

- Hospital supplied apparel must **not** leave Hospital grounds.
- Hospital supplied apparel may be worn off hospital grounds when an employee is on duty; ie. E.R. and R.N out in the field.
- On-Call does **not** apply to the above exception.
- When an employee has soiled and/or damaged his or her own clothes or uniform, with the supervisor's approval, a temporary hospital supplied scrub suit may be issued through the Environmental Serfvices~~Linen~~ Department. This employee will be responsible to return the scrub suit to their supervisor on their next scheduled work day.

If any person is observed leaving the hospital grounds with hospital apparel, disciplinary action may be taken.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~04/29/04~~ (14) ~~Plant Services~~ Environmental Services~~Housekeeping~~: Hospital Supplied Scrub Suits and Wearing Apparel 14-2006

Approved:

Board of Directors: ~~04/28/04~~

Descriptive Name:	Hospital Supplied Scrub Suits and Wearing Apparel
Descriptive Type:	Revised
Document Number:	14-2006
Attachments:	None
Author:	~~Robert Montion~~Lionel Machado
Typist:	Lionel Machado~~Jody Ellis~~
Creation Date:	3/20/03
Revision Date:	04/04/18
Prev. Dist. Date:	5/25/00

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~04/28/04~~	

Effective Date:	~~04/29/04~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution – Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Linen Utilization

I. Policy

This policy outlines a series of utilization practices to manage linen consumption while meeting the needs of patients, visitors and staff.

II. Procedure

A. Clean Linen is provided to all patients as needed and is provided to each unit as set par levels by the Environmental Service staff.
B. Conservations of linen are practiced by all caregivers. Bed linen is changed only when soiled or damp. Pillowcases are changed daily. Bed linens need to be changed at least every three days. In the event, a patient requests a change of bed linen~~.~~ T~~t~~his should be accommodated as quickly as possible.
C. Spreads are changed only if soiled. Only one spread is used per bed. An added bath blanket is used for those patients who require more warmth. Place a bath blanket between the patient and flat sheet to provide a thermal effect.
D. Pillows are reusable. They are covered with a material, which is stain, bacteria and fungus resistant. They are non- allergenic and are wiped with disinfectant between patients and when stained.

- Pillows should not be discarded, sent home with patient or sent to the laundry for washing.
- One (1) pillow is provided for each patient bed.
- Use additional pillows to position patient instead of linen items if positioners are not available.

E. The bath blanket is retained with the patient until soiled or requested to be changed.~~.~~
F. Linen used on gurneys and wheelchairs for patient transportation should be put in soiled linen after use.
G. Linen is not used to restrain patients.
H. The~~se~~following ~~-~~are ~~the~~ standard linen items used to make patient beds:

STANDARD/PRESSURE REDUCTION MATTRESS

(1) Fitted Sheet
(1) Pillowcase
(1) Pillow (add as needed)

~~Add As Needed~~

(1) Incontinence Pad
(1) Flat Sheet
(1) Blanket/Spread

I. Use only 'that which is required, and the thinnest materials necessary between the surface and the patient at all times.
J. **Do not place alternate layers of flat sheets and incontinence pads between the patient and the surface. This reduces the effectiveness of the mattress surface and increases the incidence of pressure ulcer development.**
K. Separation of clean and soiled linen is maintained at all times.
L. Care is taken when restocking and pulling linen off the linen cart so that clean linen does not fall to the floor. Keep linen cart covered.~~Cover the linen cart.~~
M. All soiled linen is treated as if it is potentially infectious. If linen is soiled with blood or body fluids, it is to be place into the soiled linen bag. It is not to be placed into red bags or discarded into the regular trash.
N. Soiled linen is bagged at the point of use and the bag is tied when it is ¾ full. This should be done before it is transported to soiled pick-up areas. Overloading of the bags may result in employee injuries when lifting and transporting.
O. Clean, defective linen (stained or torn) is returned to the designated reject linen area.
P. Linen should be used for its intended purpose:

- Do not use for spills. Mops and rags are available for this purpose.
- Hospital linen is not to be used by staff for personal convenience or warmth.
- Linen should not be used to cover equipment not in use.

Q. Any tape used on linen is removed before the soiled linen is placed into a bag.
R. Agencies, which transport patients to convalescent homes or residences, are expected to provide their own linen.
S. Do not store excess linen in patient, exam or treatment rooms. ~~a patient's room. This linen, if not used, needs to be laundered once the patient has been discharged.~~
T. Visitor linen is available upon request.
U.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Linen Utilization

Descriptive Type: New

Document Number: 14-2007

Attachments: None

Author: Lionel Machado~~Cesar Ledezma~~

Typist: Lionel Machado~~Julie Gresham~~

Creation Date: 02/27/14

Revision Date: 04/04/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~06/25/14~~	

Effective Date: ~~06/26/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE DISTRICT HOSPITAL

POLICY/GUIDELINE MANUAL

TO : All Departments

FROM : Administration

SUBJECT: Work Order Request

POLICY:

It shall be the policy of the EngineeringMaintenance Department to utilize work/repair requests to formalize and facilitate the maintenance and repair needs of the hospital.

PURPOSE:

The work/repair request will facilitate the Maintenance Engineering Department in planning, scheduling and follow-up of work. It will aid the issuing department in notifying the Maintenance Department, tracking and follow-up of work being performed. Finally, it will allow hospital personnel to be aware of malfunctioning equipment or systems in the hospital.

PROCEDURE:

A. When a Hospital Employee determines that a piece of equipment or a part of the building/grounds is in need of repair or maintenance, that individual must submit a work/repair request to the EngineeringMaintenance Department. If the request is urgent, the Employee may telephone the request only if that individual subsequently completes the work/repair request form.

B. The work/repair request form must be complete as to department, a description of the problem or work to be performed, a signature of the individual requesting the work and a control number of the equipment if applicable.

C. Work orders available on Internet Explorer.
   1. Click on Forms
   2. Click on TDH Facility Maintenance Work Orders or,
   3. Click on TDH Safety Walk Work Order, if repair is discovered during a Safety Walk Survey
   4. All sections must be completed.

D. Work orders can be submitted by:
   1. E-mail
   2. Fax

Board of Directors: ~~09/24/08~~

3. Mail Box
4. Voice Mail

E. Person completing the work order will need to attach a copy of the work order to equipment or system requiring the work,, this will act as an equipment tag out.

F. Upon completion of the work, a copy must be signed by department representative.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Work Order Request

Descriptive Type: Revised

Document Number: 14-3001

Attachments: None

Author: Lionel Machado~~Noe Cavazos~~

Typist: ~~Hillary Keith~~

Creation Date: 02/04/08

Revision Date: 04/04/18

Prev. Dist. Date: 09/27/05

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~07/30/08~~	
Board of Directors	~~09/24/08~~	

Effective Date: ~~09/25/08~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Patient's Use of Own Equipment

In an effort to provide the safest possible environment for patients, visitors, and staff, and to insure compliance with the Federal Occupational Safety and Health Act (OSHA), the following policy is established. Electrical equipment owned by patients for use in the hospital needs to be checked by the hospital Engineering staff prior to utilization to insure all electrical safety requirements.

Exclusion to this policy is life support equipment such as a ventilator. Any patient presenting to Tulare Regional Medical Center (TRMC) as ventilator dependent on their own ventilator, shall be switched over to TRMC's own ventilatory equipment. If the care cannot be facilitated safely due to lack of equipment or other circumstances, the patient will need to be transferred to a higher level of care.

Electrical equipment owned and requested for use by patients while in the Hospital must be insured safe. The following procedure shall be adhered to:

1. Engineering Department will be contacted.

2. The Engineering Department shall insure the equipment is electrically safe, has proper guards affixed, the cord and plug is in good repair and there is an underwriters approval sticker on the appliance. Use of three prong plugs, etc., will be evaluated by the Engineering~~Maintenance~~ staff. Once the equipment has been checked and approved, an "inspected" sticker will be affixed or taped to the equipment by the Engineering~~Maintenance~~ staff.

3. The Engineering staff will return the equipment to the Nursing Unit.

4. The nurse in charge will insure the form, "Patients Request to Use Own Equipment, is properly and completely filled out and signed by the patient and a witness. (Witness may be a hospital employee).

Effective Date: ~~11/20/14~~ (14) Engineering Department~~Plant Services Maintenance~~:

Patients Use of Own Equipment
14-3002

APPROVED:

Medical Executive Comm.: ~~11/05/14~~

Board Of Directors: ~~11/19/14~~

POLICY / GUIDELINE

Equipment not complying with OSHA standards and hospital safety requirements will be rejected. The patient will be so appraised and will not be permitted to use the equipment in TRMC.

Battery operated equipment is preferred in order to eliminate trip hazard of electric cords. **Use of extension cords is strictly prohibited.**

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

PATIENT'S REQUEST TO USE OWN EQUIPMENT

I, _____ assume all responsibility in the use of my _____ which I have brought to Tulare Regional Medical Center for my own convenience while a patient at Tulare Regional Medical Center.

Tulare Regional Medical Center has inspected this piece of equipment, _____ and approved it for use in the hospital.

_____ _____ _____
Patient Time
Date

_____ _____ _____
Signature of Hospital staff Time
Date

Descriptive Name: Patient's Use of Own Equipment

Descriptive Type: Revised Policy

Document Number: 14-3002

Attachments: Included

Author: Lionel Machado

Typist: Melissa Arend

Creation Date: 08/28/03

Revision Date: ~~08/12/14~~

Prev. Dist. Date: 09/27/07

Committee Review and Approval:	Approval Date:	Comments:
EOC Committee	~~07/24/14~~	
MEC	~~11/05/14~~	
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO : All Departments

FROM : Administration

SUBJECT: Moving of Beds, Furniture, TV's and other furnishings.

In an effort to clarify responsibility for and coordination of equipment and furnishing moving, the following policy is established:

1. Beds, Cribs, Etc.

a. EngineeringMaintenance personnel shall be contacted should it be necessary to move any beds, cribs, cots, etc., to or from the patient rooms from storage. EngineeringMaintenance shall check the item for proper mechanical function prior to placing it into service or removing it from service.

b. EngineeringMaintenance shall set the item up at the site it will be used, insuring it functions properly. Environmental ServicesHousekeeping and/or Nursing Services shall clean and prepare the item for use (i.e., make the bed, clean it, etc.).

2. Furniture, Tables, desks, Etc.

All departments shall move their own furnishings as much as possible with their own personnel. When there is need for assistance, the request shall be sent to MaintenanceEngineering who shall coordinate the move (s) with Environmental ServicesHousekeeping. **Moves shall be pre-scheduled as much as possible.**

3. Conference Rooms

Environmental ServicesHousekeeping shall prepare the Conference rooms on a timely basis for each meeting in using request for set up forms available in administration. Environmental ServicesHousekeeping shall coordinate any additional assistance needed with EngineeringMaintenance.

4. Televisions

EngineeringMaintenance personnel shall be responsible for all television transport. Staff other than EngineeringMaintenance is expressly prohibited from moving any television.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Effective Date: ~~10/23/08~~	(14)	Engineering/~~Plant Services~~ Environmental
Services~~Housekeeping/Maintenance~~:		
Approved:		Moving of Beds, Furniture, TV's and other furnishings
Board of Directors: ~~10/22/08~~		14-3005

Descriptive Name: Moving of Beds, Furniture, TV‘s and other furnishings

Descriptive Type: Revised

Document Number: 14-3005

Attachments: None

Author: Lionel Machado~~Noe Cavazos~~

Typist: ~~Hillary Keith~~

Creation Date: ~~02/04/08~~

Revision Date: 01/11/18

Prev. Dist. Date: 09/27/05

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~09/24/08~~	
Board of Directors	~~10/22/08~~	

Effective Date: 10/23/08

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Staff

FROM: Administration

SUBJECT: Safeguarding Disaster Preparedness Two-way Radios

This policy is established to safeguard hospital owned hand held radios:

1. Radios shall not be removed from the hospital premises without prior approval from Emergency Preparedness Coordinator and/or Administration.

2. Radios shall not be used for personal use.

3. Radios shall be stored and secured in the Medical Staff Conference room cabinet.

4. Disbursement of radio's will be documented in the binder located on the top of the Disaster Cart – time, date out, and name of person taking radio will logged next to radio number. Any individual who checks out a radio will be responsible for its safe return to the Medical Staff Conference room cabinet.

5. Keys for radios shall be located in PBX~~, the office of the VP of Quality, with~~and/or with Emergency Preparedness Coordinator ~~and Nursing Supervisor~~.

6. All two-way radios and chargers will have permanent identification inscribed upon them. .

7. Any missing radios and/or chargers will be immediately reported to the Emergency Preparedness~~Management~~ Coordinator.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: ~~04/04/13~~ (14) Engineering Department~~Plant Service Maintenance~~:

Approved: Safeguarding Disaster Preparedness Two-Way Radios 14-3013

Board of Directors: ~~04/03/13~~

Descriptive Name: Safeguarding Disaster Preparedness Two-Way Radios

Descriptive Type: Revised

Document Number: 14-3013

Attachments: None

Author: Lionel Machado

Typist: ~~Jennifer Bridges~~Lionel Machado

Creation Date: ~~02/07/13~~

Revision Date: 01/11/18

Prev. Dist. Date: 09/25/08

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~02/28/13~~	
Board of Directors	~~04/03/13~~	

Effective Date: ~~04/04/13~~

Forward To: Policy Binders – (PBX and Administration) and Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Recording Refrigerator/Freezer, Medication and Lab Specimen Temperatures

The following policy is established to insure that temperatures of all refrigerators and freezers in the hospital are recorded on a regular basis:

1. There are three (3) basic classifications of refrigerators and freezers that need to meet various regulatory requirements:

   a. Refrigerator temperature for Lab, Medicine and/or Drugs will be maintained between 36° F and 46° F (2°C and 8°C).

   b. Refrigerator temperature for Lab will be maintained between 34°F and 43°F (1°C and 6°C).

   c. Refrigerators in the Food Service Department that store readily perishable foods or beverages capable of supporting rapid and progressive growth of microorganisms which can cause food infections or food intoxication, shall be maintained at temperatures of 40°F (4°C) or below. (Referenced according to NSF Standards). Freezers in the Food Service Department will be maintained at 0°F (-18°C) or below.

   d. Patient refrigerators in patient care areas shall be maintained at temperatures of 45°F (7°C) or below. (Referenced according to Title 22, Section 70273 #3). Patient freezers will be maintained at 0°F (-18°C) or below.

   e. Storage of lab specimens in the patient care units will be kept at 36° F (2°C) to 46° F (8°C) in a separate, dedicated refrigerator. The Plasma Freezer will be maintained between -4°F and -22°F (-20°C and -30°C).

   f. Pharmacy Freezer for IV Frozen drugs shall be maintained between -4°F and -22°F (-20°C and -30°C).

2. Each department is responsible for recording the temperature of each refrigerator and/or freezer in their department on at least a daily basis. There may be regulatory

3. Rrequirements for certain departments to log temperatures on a more frequent basis (e.g., Medication refrigerators with vaccines). A temperature log form is available in each department. **attached** to this policy which may be copied as necessary. The log may be kept in a convenient place such as attached to the refrigerator/freezer, kept in a drawer or cabinet nearby.

4. Requirements for minimum and maximum temperatures vary from department to department and need to be documented in the space provided on the log sheet. Should the temperature fall below the minimum requirement or higher than the maximum requirement, the Engineering Department needs to be notified by use of a Work Order. Emergency situations would be handled by telephone to Engineering Department. Staff shall document on the daily temperature log the date, time, and name of the individual from Engineering that was contacted.

   If a refrigerator or freezer is found to be outside the normal operating temperature range, immediately check the contents of the refrigerator/freezer. Contact Food Services, Pharmacy Services, Laboratory, or the Nursing Supervisor if Food Service or Pharmacy Services is unavailable to determine if any product/food/drug/lab specimen has been damaged. Transfer the contents of the refrigerator/freezer to a properly operating unit until appropriate repairs can be made. Engineering shall document on the daily temperature log the date when repairs are completed and the unit is returned to service.

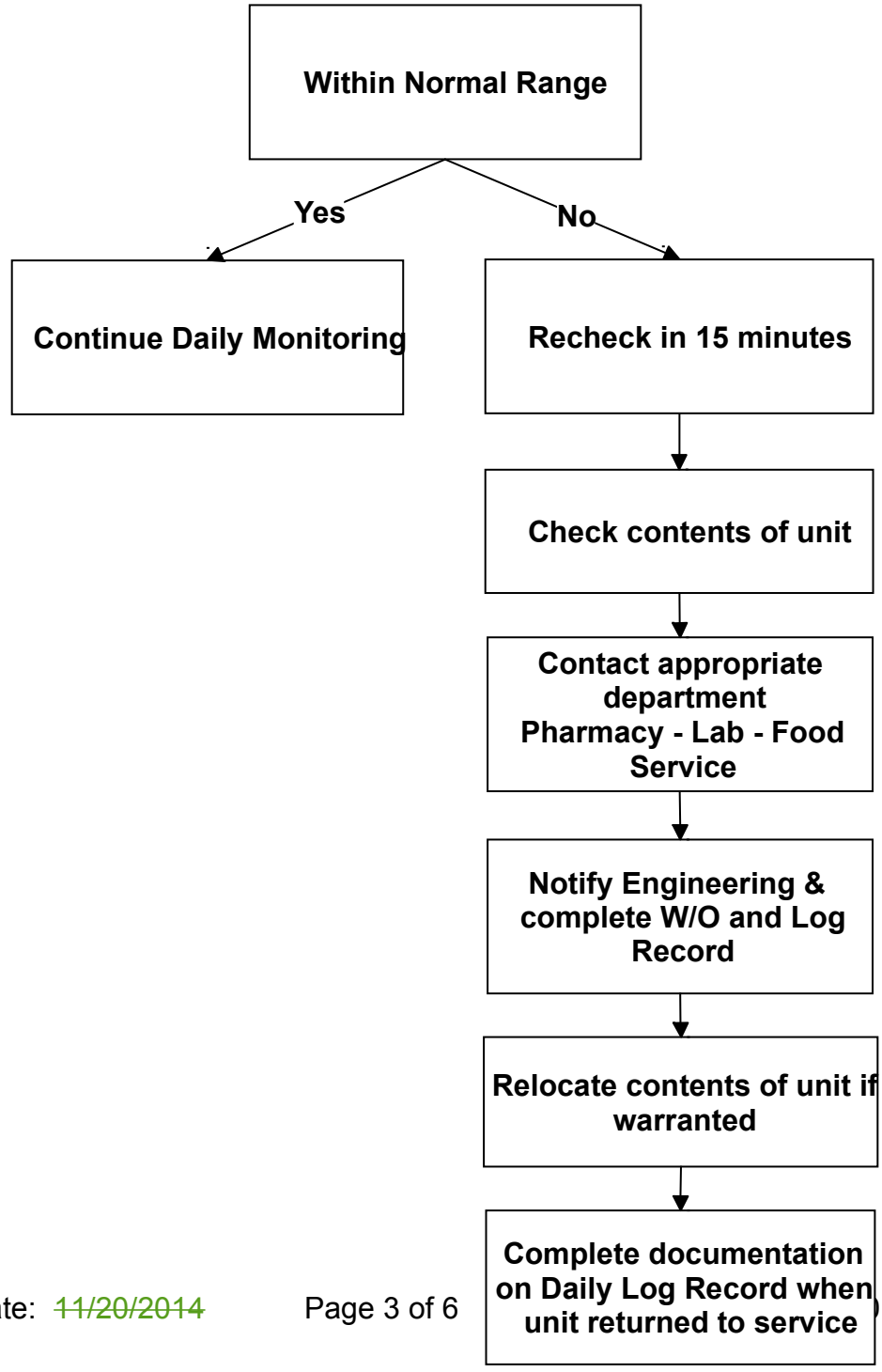
   Temperature logs are to be retained by the department for three (3) years.

   Departments that have refrigerators and/or freezers are responsible for establishing a process within the department for maintaining the logs.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Daily Temperature Log for Refrigerator /



POLICY / GUIDELINE

Tulare District Hospital

PATIENT REFRIGERATOR - FREEZER TEMPERATURE LOG

The temperature must be taken at least once within a 24-hour period. If the temperature is out of normal operating range, recheck in 15 minutes. **If the refrigeration temperature ***greater than 46°F* for food storage or for Freezer sections of frozen food storage *is greater than 0°F.* **PLEASE NOTIFY ENGINEERING. PLACE A CHECK MARK IN THE BOX THAT CORRESPONDS WITH THE TEMPERATURE NOTED.**

Month _____ Year _____

Date	STAFF SIGNATURE	45° OR LESS	46° OR ABOVE	0° OR BELOW	ABOVE 0°	HIGHLIGHTED AREAS REQUIRE AN ACTION TO BE TAKEN	ACTION RESPONSE BY ENGINEERING	MAINT INITIAL
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TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Tulare District Hospital

TEMPERATURE LOG

A. **MEDICATION AND LAB SPECIMENS REFRIGERATORS**

****The temperature must be taken at least once within a 24-hour period. If the temperature is out of normal operating range, recheck in 15 minutes. **If the refrigeration temperature is less than *36°F (2°C) or greater than 46°F (8°C)* for medication and Lab specimen storage, PLEASE NOTIFY ENGINEERING. PLACE A CHECKMARK IN THE BOX THAT CORRESPONDS WITH THE TEMPERATURE RANGE.**

Month _____ Year _____

Date	STAFF SIGNATURES	35° OR BELOW	36°	37°	38°	39°	40°	41°	42°	43°	44°	45°	46°	47° OR ABOVE	*HIGHLIGHTED AREAS REQUIRE ACTION TAKEN*	ACTION TAKEN BY ENGINEERING	*MAINT* INITIALS
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Tulare District Hospital

PATIENT REFRIGERATOR - FREEZER TEMPERATURE LOG

The temperature must be taken at least once within a 24-hour period. If the temperature is out of normal operating range, recheck in 15 minutes. **If the refrigeration temperature ***greater than 46^{0}F* for food storage or for Freezer sections of frozen food storage *is greater than 0°F.* **PLEASE NOTIFY ENGINEERING.**

PLACE A CHECK MARK IN THE BOX THAT CORRESPONDS WITH THE TEMPERATURE NOTED.

Month _____ **Year** _____

Date	STAFF SIGNATURE	45° OR LESS	46° OR ABOVE	0° OR BELOW	ABOVE 0°	HIGHLIGHTED AREAS REQUIRE AN ACTION TO BE TAKEN	ACTION RESPONSE BY MAINTENANCEENGINEERING	MAINT INITIAL
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Descriptive Name: Recording Refrigerator/Freezer Temperatures

Descriptive Type: Revised

Document Number: 14-3016

Attachments: Included

Author: ~~King Janes/Julie Gresham/~~King Janes/Julie Gresham~~Andrea Carrasco/Ena Menezes~~

Typist: ~~Melissa Arend~~Andrea Carrasco/Ena Menezes

Creation Date: 08/11/08

Revision Date: ~~09/18/14~~ 01/31/18

Prev. Dist. Date: 02/26/09

Committee Review and Approval:	Approval Date:	Comments:
EOC Committee	~~10/23/14~~	
Board of Directors	~~11/19/2014~~	

Effective Date: ~~11/20/2014~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Use of Fire Hoses

In the event of a fire at Tulare Regional Medical Center, the fire hoses are to be used by Tulare Fire Department Trained personnel only.

All Tulare Regional Medical Center personnel shall follow Hospital Policy #21-2001 Code Red - Fire Plan.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Use of Fire Hoses

Descriptive Type: Revised

Document Number: 14-3019

Attachments: None

Author: Lionel Machado~~/Andrea Carrasco/Ena Menezes~~

Typist: Melissa Arend/Andrea Carrasco/Ena Menezes

Creation Date: 09/27/05

Revision Date: ~~08/21/14~~ 02/01/18

Prev. Dist. Date: 09/27/05

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care Committee	~~08/21/14~~	
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Staff

FROM: Administration

SUBJECT: Air Transport Landing Procedure

It is a policy of Tulare Regional Medical Center that **NO** helicopter's or small aircraft will land on hospital grounds. All requests for air transport will be directed to land at Mefford Airport in Tulare or the closest available airport. Ambulance transportation will be arranged to transport the patient to the airport.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Air Transport Landing Procedure

Descriptive Type: Revised

Document Number: 14-3021

Attachments: None

Author: Lionel Machado

Typist: ~~Melissa Arend~~

Creation Date: 10/26/06

Revision Date: ~~08/12/14~~

Prev. Dist. Date: 09/25/08

Committee Review and Approval:	Approval Date:	Comments:
Environment of Care	~~07/24/14~~	
Board of Directors	~~11/19/14~~	

Effective Date: ~~11/20/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Nursing Services

FROM: Administration

SUBJECT: RN Certification Recognition Program

PURPOSE

The RN Certification Recognition Program is established to promote excellence in nursing practice, through the recognition and support of specialty nursing certification.

PROGRAM COMPONENTS

The following are components of the program to be provided to each certified RN:

1. Upon completion of initial certification, RN will be reimbursed for review course and testing fees up to $500.

2. Thereafter, $500/yr. will be available in their home department's budget, to be used at the certified RN's request for costs related to maintaining certification: ~~(~~ seminar/webinar fees, professional organization membership dues, journal subscriptions and recertification fees~~)~~. Note: the $500/yr. is renewed annually, is not cumulative, and is available as long as the RN maintains certification in their specialty.

3. The certified RN will receive a new name tag, reflecting the certification status.

GUIDELINES FOR PARTICIPATION

1. Certification must be attained through a nationally recognized professional nursing organization that requires experience in the specialty, a passing score on a comprehensive exam, and regular recertification periods.

2. Participation in the program will begin after achieving certification, not during the testing process.

3. The certified RN must be a full-time or part-time employee, with a minimum of one-year employment at Tulare Regional Medical Center. If employee's status changes to per diem, employee will no longer receive certification reimbursement.

4. If a certified RN is routinely scheduled to work more than one department, program participation will be based in the department utilizing the majority of their annual worked hours.

5. If a certified RN is working in a department not directly related to their specialty, and the required knowledge related to the certification is beneficial to, but not directly and actively utilized in the RN's current position, their program participation will be determined on an individual basis by the Chief Nursing Officer/Chief Operating Officer in collaboration with their Department Director.

6. If an RN has achieved certification in two nursing specialties, both will be recognized and identified on the RN's name badge. The second certification will be eligible for a reimbursement of $250.00 annually, subject to the same guidelines as the initial certification. Employee will only be reimbursed up to two certifications.

PROGRAM IMPLEMENTATION

1. Certification Account:

   A. All program participation, monitoring of certification status, and utilization of the certification account, will be coordinated by Clinical Administration.

2. Procedure for Participation:

   A. Initial Certification: The newly certified RN shall submit the following to their Director, who will forward to Clinical Administration: (copies only)

      1. The notification letter stating the RN has successfully achieved certification. When received, a copy of the certification card or document that reflects the certification number and expiration date.

      2. Receipts indicating testing fees that were paid.

      3. Receipts indicating the registration fees and the CE certificate of attendance or completion for any review course or study program.

   B. Utilizing the Certification account: The certified RN will submit the following to their Director, who will forward to Clinical Administration: (copies only)

      1. For seminar/webinar:

         a. Prior to the seminar/webinar, complete a "RN Certification-Expense Account" form for pre-approval.

b. Once seminar/webinar is approved, RN will submit a copy of receipt of payment for seminar/webinar fee and the previously approved “RN Certification-Expense Account” form.

2. For costs related to professional organization membership dues, journal subscriptions and recertification fees:

a. Complete a "RN Certification-Expense Account" form

b. Attach receipts of payment.

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

Department of Clinical Services

RN Certification - Expense Account

NAME _____ Date_____ Dept. # _____.18

NATURE OF EXPENSE (Describe each item. Attach copies of all applicable receipts)

1.	**INITIAL CERTIFICATION REIMBURSEMENT:**	
	a) **Testing Fees**	$
	b) **Review Course Registration Fees**	$
2.	**RECERTIFICATION FEES (to renew certification status)**	$
3.	**MAINTAINING CERTIFICATION:**	
	a) **Seminar/Webinar Fees:**	$
	b) **Professional Organization Membership Dues:**	$
	c) **Professional Journal Subscriptions:**	$
	TOTAL EXPENSES	$

Other Instructions/Information_____

_____

CERTIFIED RN'S BALANCE:

Current Balance $_____

This Request $_____

Remaining Balance $_____

Signature of Individual _____ **Date** _____

Signature of Department Director _____ **Date** _____

Signature of CNO/COO _____ Date _____

Descriptive Name: RN Certification Recognition Program

Descriptive Type: Revised

Document Number: 15-2061.1

Attachments: Yes

Author: Tammy Kegler~~Wafa Elmusselmani~~

Typist: ~~Melissa Arend~~Carol Bradford

Creation Date: 02/04/04

Revision Date: 01/17/18

Prev. Dist. Date: ~~03/12/04~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~04/23/14~~	

Effective Date: ~~04/24/14~~

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

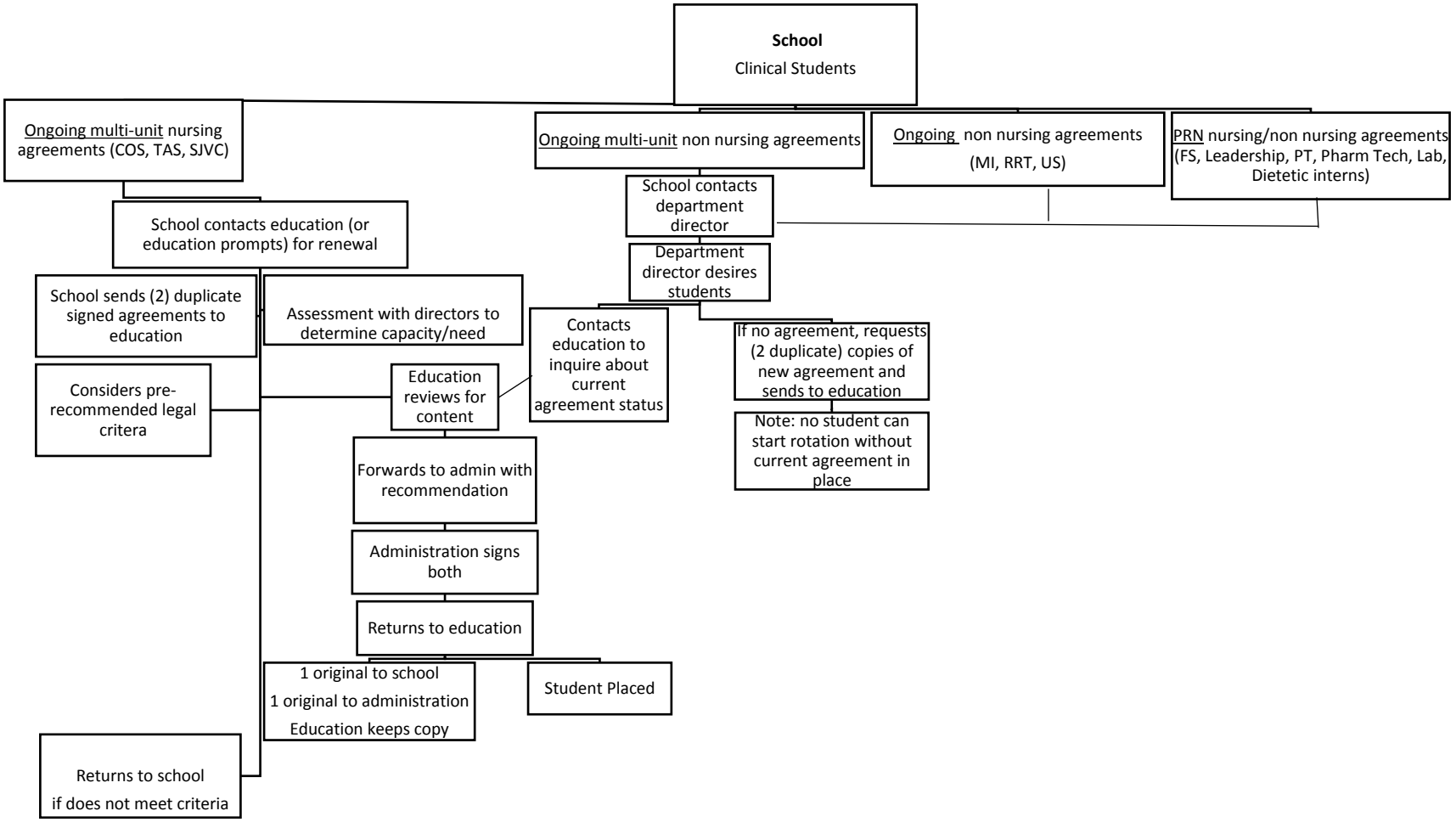
Comments:

TULARE LOCAL HEALTHCARE DISTRICT

dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE

Appendix A **Student Agreement Process**

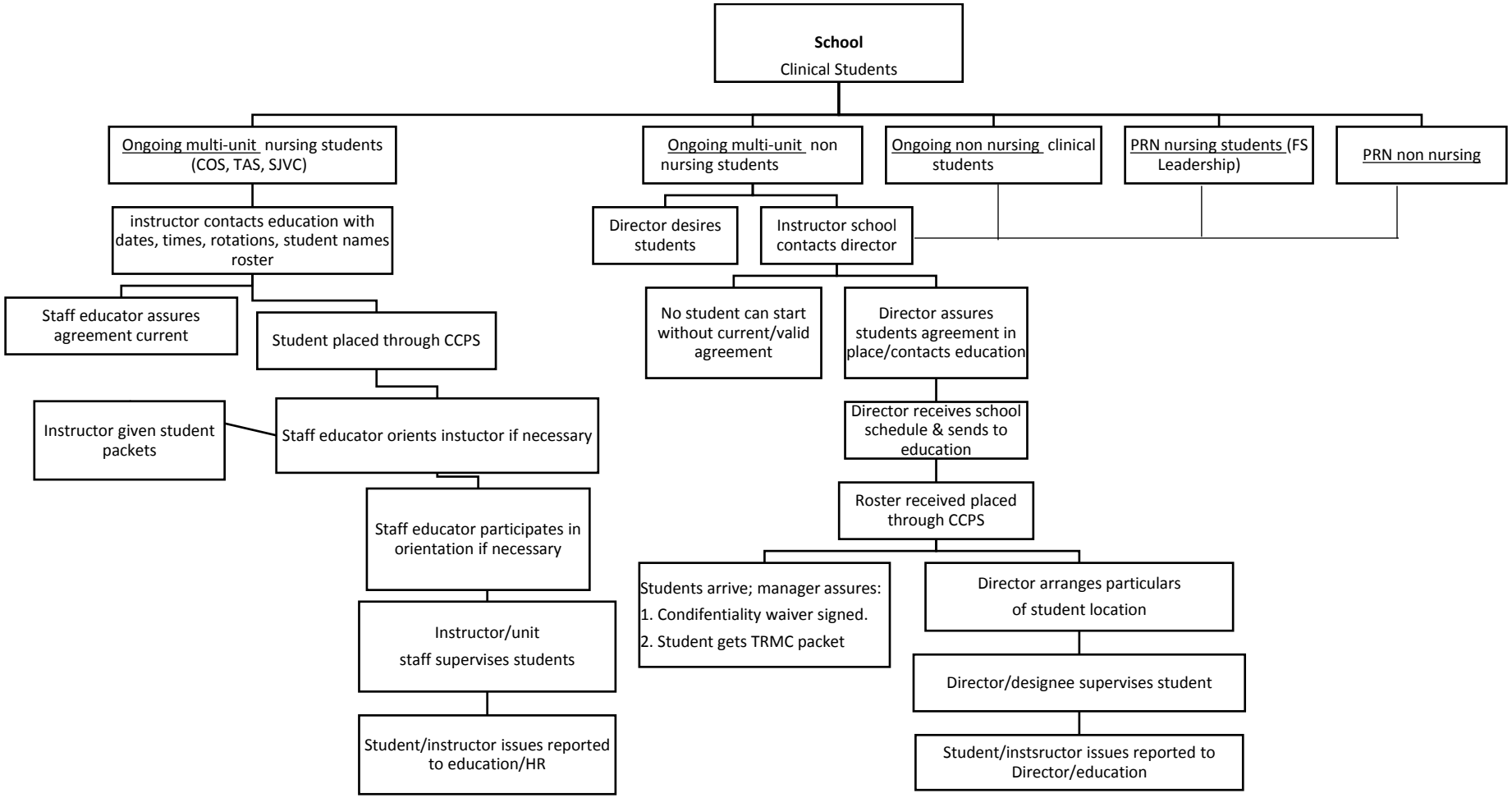


TULARE LOCAL HEALTHCARE DISTRICT

dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE

Appendix C **Student Scheduling Process**



TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Student Affiliations ~~and Sponsorships~~

As a healthcare facility, Tulare Regional Medical Center (TRMC) has an opportunity to offer a wide variety of student experiences. Through mutual collaboration and structure, TRMC and academic institutions can equally benefit from the enhancement of competency and service to our patients and community by facilitating positive, nurturing, and safe student experiences.

The purpose of this Policy is ~~two-fold. First, this Policy~~to detail~~s~~ the Student Affiliation process by: (a) identifying the procedure for establishing and maintaining written agreements/contracts with educational institutions for the placement of its students at TRMC; and (b) identifying the student placement procedure. ~~Second, this Policy sets forth the requirements of the Student Sponsorship Program, designed to develop and retain competent and knowledgeable employees.~~

~~The Policy is divided as follows:~~

~~I. Student Affiliations~~
~~A. Contracts~~
~~B. Student Placement~~
~~II. Student Sponsorship Program~~

I. Student Affiliations

A. Agreements/Contracts (*See Appendix A ~~Students Contract Matrix and Appendix B~~ -Student Agreement (Contract) Process*)

1. Prior to a particular student beginning a rotation at TRMC, there must be a fully-executed agreement~~contract~~ between the student's educational institution ("Institution") and TRMC.

2. Department Managers/Directors are responsible for assuring a fully-executed agreement~~contract~~ between the Institution and TRMC exists, prior to permitting a student to begin his/her rotation in the ~~Director's~~Manager's department.

3. TRMC Education Department ("Education") shall evaluate and reassess agreements~~contracts~~ on an ongoing basis to ensure they are valid and up-to-

date. It shall be Education's responsibility for recommending, to TRMC Administration, execution of agreements~~contracts~~ with Institutions who have not previously held such an agreement ~~contract~~ with TRMC.

4. All agreements~~contracts~~ shall contain, at a minimum, the following information:

- **General information/responsibilities about the program**
- **Facility responsibilities**: student supervision, assuring the safety and welfare of TRMC patients.
- **Student responsibilities**: adherence to TRMC policies and procedures, including HIPAA requirements/confidentiality, dress code, assignments, orientation, CPR current certification (licensed programs only i.e. RN-LVN), emergency health situations/student insurance.
- **Type of students:** RN, leadership, LVN, Pharmacy Techs, RT, ~~.~~ etc.
- **Programs to be considered**-some schools combine all their programs into one agreement~~contract~~.
- **Institution responsibilities:** ~~States in contract~~ Institution will (1) "*provide competent, fully credentialed and safe instructors in their field (credentials will be available on request). (2) All policies and rules of TRMC will be adhered to by instructors and students and (3) ~~The~~the ~~hospital~~facility will reserve the right to dismiss students or faculty from performing patient care at TRMC based on the safety and welfare of patients."*
- Submit attached "*Affiliated School Roster*" (**Appendix B~~C~~)** with required immunizations and background check clearance *prior* to students starting rotation.
- **Commence date and expiration date**. Renewal ~~for one or two years only~~period varies among academic institutions. "Evergreen" (no expiration date) not accepted.
- **Insurance coverage and Workmen's Compensation**-liability to name facility as an additional insured.
- **Business Associates Agreement:** Not required for public Institutions
- **Termination:** Facility has the right to terminate the agreement~~contract~~ based on the immediate safety and welfare of patients~~, if necessary. Clause~~.
- **Indemnification clause**
- **No monetary** obligation to facility
- **Agency submits:** two (2) original *signed* fully executed contracts to Institution.
- **Supplies:** at the expense of the school.
- **Parking:** is not available on site. *Access available street side only.*
- **Conference room space:** is not guaranteed, *only* if available.
- **Student number:** to be determined each term by TRMC, based on capacity.
- **Institution name(s):** Tulare Local Health Care District dba Tulare Regional Medical Center. ~~– leave signature area blank~~

5. Agreement~~Contract~~ approval (***See Appendix A~~B~~***):

   i. Ongoing multi-unit nursing agreements~~contracts~~ (i.e., COS, TAS, SJVC)

- Institution contacts TRMC Education (or Education prompts the contact to initiate agreement~~contract~~ renewal) to negotiate a new agreement~~contract~~ or ~~contract~~ renewal. The process to renew an agreement ~~contract~~ must commence *at least* two months in advance. Institution delivers two (2) signed duplicate agreements~~contracts~~ to Education.
- Education and Department Manager~~Director~~s assess TRMC need and capacity for student placements/affiliation.
- Education reviews the agreement~~contract~~ against required criteria as described in Section I.A.4 of this Policy.
- Agreement~~Contract~~ returned to Institution for revisions if it does not meet ~~the~~ criteria. Agreement~~Contracts~~ forwarded to Administration, if criteria met.
- Administration obtains legal opinion, if necessary, signs both agreements~~contracts~~, and returns both ~~contracts~~ to Education.
- Education returns one original and fully-executed agreement~~contract~~ to Institution.
- Education places a fully-executed copy in its files and returns fully-executed original to Administration.
- Student(s) placed.

ii. Ongoing multi-unit clinical agreements~~contracts (i.e, paramedics)~~; ongoing non-nursing clinical agreements~~contracts~~ (MI, RRT, US); and PRN nursing/non-nursing agreements~~contracts~~ (~~FS/I~~Leadership, Pharm tech, Lab, Dietetic interns, Admin. Asst.)

- Same process as I.A.5.i of this Policy.
- TRMC retains sole discretion regarding which of the Institution's students are placed and the total number of students placed.

~~iii. Ongoing non-clinical Department contracts (TAS-Admin. Asst.)~~

~~Same process as I.A.5.i of this Policy, only Human Resources (rather than a Department Director) facilitates the process.~~
~~Human Resources coordinates student placement with Department Director.~~

B. **Student Placement** (*See **~~Appendix D~~** ~~Student Placement Matrix~~* and ***Appendix C~~E~~*** *~~-~~Student Scheduling Process*)

1. Ongoing multi-unit nursing agreements~~contracts~~ (i.e., COS, TAS, SJVC)

- Institution's Instructor contacts Education with dates, times, and rotation particulars.

- Education assures ~~contract~~ current agreement in place. *No student can start rotation without current /valid agreement~~contract~~.*
- Student(s) placed through Computerized Clinical Placement System (CCPS)~~on Student Placement Matrix **Appendix D**~~.
- Education orients Institution's Instructor to TRMC procedures and requirements, as needed.
- Education gives Institution's Instructor student packets~~/DVD~~.
- Education orients Institution's Instructor and/or students regarding TRMC procedures and equipment, as necessary.
- Institution's Instructor and TRMC Department Manager~~Director~~ (or his/her designee) oversees and supervises students.
- Student placement issues raised by students, Institution's Instructor, and/or Department Manager~~Director~~ are reported to Human Resources and Education for resolution.

2. Other agreements~~contracts~~-ongoing multi-unit clinical agreements~~contracts~~ ~~(i.e, paramedics~~, ongoing non-nursing clinical agreements~~contracts~~ (MI, RRT, US), PRN nursing/non-nursing agreements~~contracts~~ (~~FS/I~~Leadership, PT, Pharm tech, Lab, Dietetic interns)

- Institution's Instructor contacts appropriate Department Manager~~Director~~.
- Department Manager~~Director~~ assesses need and capacity for student placements.
- Department Manager~~Director~~ coordinates with Education to determine current agreement~~contract~~ is on file. *No student can start rotation without current/valid agreement~~contract~~.*
- Department Manager~~Director~~ receives Institution's class schedule and sends to Education.
- Education tracks~~places~~ class schedule placed through Computerized Clinical Placement System (CCPS) with the Central Valley Academic Service Partnership~~on Student Placement Matrix **Appendix D**~~.
- Student begins rotation. Department Manager~~Director~~ assures confidentiality waiver signed (per Policy #-13-12009 Hospital Orientation for Associated Staff) and returned to Education~~HR~~. Student receives TRMC packet ~~(i.e. dress code)~~.
- Department Manager~~Director~~ arranges particulars of student placement.
- Institution's Instructor and TRMC Department Manager ~~Director~~ (or his/her designee) oversees and supervises student(s).
- Student placement issues raised by students, Institution's Instructor, and/or Department Manager~~Director~~ reported to Human Resources and Education for resolution.

~~3. Ongoing non-clinical Department contracts (TAS-Admin. Asst.)~~

Institution contacts Human Resources. Human Resources assures, through Education, contract current and valid.
Human Resources contacts Department Director to determine need and capacity for student placement.
Student's TRMC folder given and student signs Confidentiality Waiver.
Student placed.

- Institution's Instructor and TRMC Department Director (or his/her designee) oversees and supervises student(s).
- Student placement issues raised by students, Institution's Instructor, and/or Department Director reported to Human Resources and Education for resolution.

II. **Student Sponsorship Program** (matching paid work hours to education hours)

A. Purpose

The Student Sponsorship Program is part of TRMC recruitment, retention, and career development plan for regular full- and part-time employees. The Program offers paid release time for staff while enrolled in an accredited post-secondary education program, in exchange for a commitment to continue working for TRMC after completion of the specified program. Sponsored employees will work up to 20 hours per week and receive up to 20 hours of matching elective training time for each week spent in class.
The numbers of Student Sponsorship spaces available are limited and available to TRMC staff seeking licensure, certification or a degree in selected career paths that meet specific staffing needs of TRMC.

1. General Requirements

i. In its sole discretion and based upon budgetary considerations, TRMC may temporarily choose to postpone the program and limit the number of students (to no more than 20)

ii. Candidates applying for the Sponsorship Program must have completed pre-requisite classes to the satisfaction of TRMC and be enrolled in a licensure or certification program at an accredited post-secondary educational institution. Candidates must also have been employed by TRMC for a period of not less than three months.

iii. Candidates employed by TRMC in the Student Intern Program must complete the first school term in order to be eligible for the Sponsorship Program.

iv. Upon acceptance into a recognized educational program, an employee who wishes to be considered for a sponsorship shall submit to the Sponsorship Review Panel:

a) The completed Sponsorship Agreement (***Appendix F***).
b) Two (2) letters of recommendation: one letter from someone not related, who knows the employee well, and one letter from the employee's immediate supervisor.
c) Evidence of enrollment at an accredited academic institution.
d) Sealed transcripts evidencing a "C" average or better.

2. Sponsorship Review Panel

i. The Sponsorship Panel will interview candidates, select candidates, and follow their progress through the program on a term-to-term basis. The Panel will make recommendations to TRMC Administration, whether an individual Student Sponsorship should be awarded, continued, and/or terminated.

ii. The Sponsorship Review Panel will consist of representation from the following departments, as appropriate: Education, Human Resources, Nursing Administration/recruiter, nursing services and clinical services.

iii. The Sponsorship Review Panel shall communicate acceptance into the Sponsorship Program to the employee prior to the beginning of the course work and/or participation in the Sponsorship Program. Termination of the employee's participation in the Sponsorship Program shall be communicated by the Sponsorship Review Panel to the employee as soon as reasonably possible.

iv. Candidates applying for the Sponsorship Program will be considered on a case-by-case basis. Current TRMC staffing needs and availability of funding will be reviewed every school term; this review may result in an increase in Sponsorship Program participants, or termination of existing Sponsorship Program participants.

v. All candidates shall submit to the Sponsorship Review Panel, at the conclusion of every school term, evidence of continued satisfactory academic participation and job performance.

vi. Sponsored employees' academic and job performance will be tracked by Education (***See Appendix F*** – *Student Sponsorship Matrix*).

3. Student Sponsorship Requirements (***See Appendix F-****Sponsorship* Agreement)

i. TRMC negotiates a salary for a variable number of hours of work (maximum matching salary is 40 hours per pay period), sufficient to allow the Sponsored employee to engage in his/her specified course of instruction.

ii. The Sponsored employee agrees to work variable hours (maximum of 40 hours per pay period). The number of hours worked while school is in session will be equally matched by TRMC with hours used for educational purposes, up to the limit.

iii. TRMC will attempt to schedule the Sponsored employee's work hours to accommodate his/her studies and to minimize the conflict between employment and scheduled course work.

iv. The Sponsored employee shall work the full number of hours (work hours plus sponsorship hours) required for his/her position, during school break periods, school holidays, and any other time that school is not in session. Hours worked during such time that school is not in session will not be "matched."

v. The Sponsored employee is responsible for providing Nursing Administration or other appropriate Department heads the Institution's classroom schedule at the beginning of each semester.

vi. Hours worked in excess of 40 will not be matched, but will be paid at the Sponsored employee's current salary range and step. Once an approved work schedule has been posted, no changes may be made in the hours scheduled without the prior consent of the appropriate Department Director or supervisor.

vii. The Sponsored employee agrees to maintain satisfactory work performance and make satisfactory progress in the sponsored educational program with a passing grade of "C" or better.

viii. All educational expenses are handled according to policy #15-2013 (Educational Assistance Reimbursement Program), if applicable. Any educational or related expenses that exceed the limitations of this Policy are the Sponsored student's responsibility.

ix. Absence Without Leave (AWOL) is deemed a violation of the Sponsorship Agreement and a basis for termination of the Agreement.

~~x. The Sponsored employee shall maintain active and satisfactory student status in the educational institution during the entire Sponsorship period to the satisfaction of TRMC.~~

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Tulare Regional Medical CenterEducational Institution Contract Matrix

Appendix A

Institution	Type	Description/Dept	Contract Number	Start Date	End Date	Status	Number of Students Yearly	Renewal Trigger	
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact
									❑ Letter ❑ Contact

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

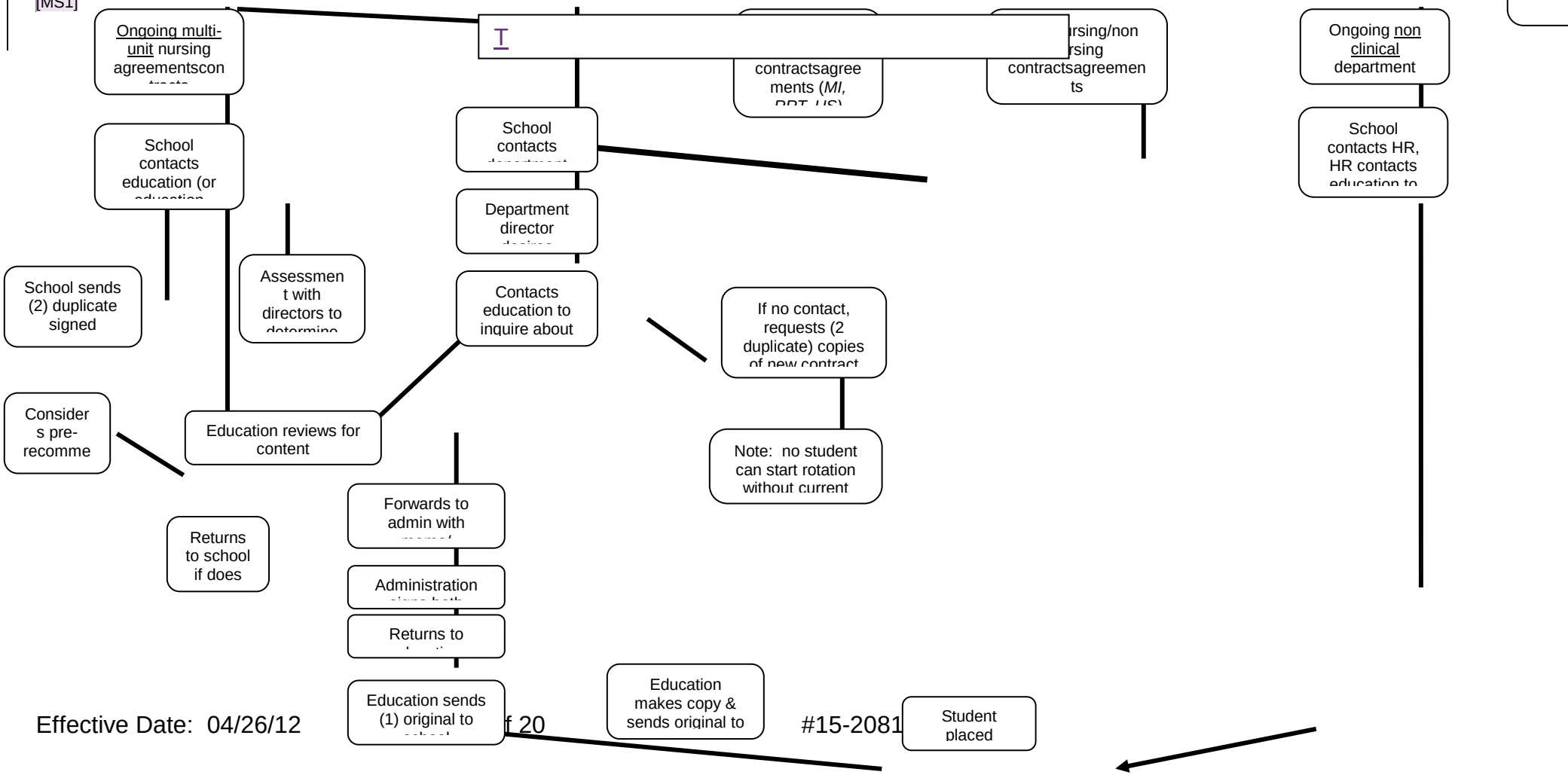
This ~~Appendix AB~~

Student

Contract Process

This flowchart deleted, new one attached Policy 15-2081 Appendix A

[MS1]



TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

AFFILIATED SCHOOL STUDENT ROSTER

Appendix BC

SCHOOL _____ **ACADEMIC YEAR** _____ **SEMESTER:** ____

TYPE OF STUDENT: □ RN □ LVN □ PHARMACY □ PT □ RT □ MA □ Other

_____

ROTATION: START _____ **END** _____

COURSE (name & number)**:** _____ **SCHEDULED DAYS** (including hours)**:** _____

COMPLETE FOR STUDENTS AND INSTRIUCTOR - SEE REVERSE FOR DETAILS OF IMMUNITY REQUIREMENTS

	PRINT Student's Name (Last name First)	Phone No.	Mumps + Titer / 1 dose (date)	Rubeola + Titer / 2 doses (dates)	Rubella +Titer / 1 dose (date)	Varicella + Titer / 2 doses (dates)	Hep B Titer / Series Declination (dates)	Liability Ins (verify date)	Back-ground Check	BLS AHA (exp date)	TB 2 PPD / CXR (dates)
1											
2											
3											
4											
5											

	PRINT Student's Name (Last name First)	Phone No.	Mumps/ 1 dose (date) or titer	Rubeola 2 doses (dates) or titer	Rubella 1 dose (date) or titer	Varicella 2 doses (dates) or titer	Hep B Series Declination (dates) or titer	TB PPD / CXR (dates)	Flu Vacc (date)	Back-ground clearance	BLS AHA (exp date)	Liability ins (verify date)
1												
2												
3												

4												
5												

Information Verified by: _____

Instructor: _____ Home Phone: _____ School Phone: _____

Address: _____ License Number: _____ Expiration Date: _____
Verified By: _____PLEASE SUBMIT THIS ROSTER BEFORE EACH ROTATION TO: _____

To protect patients – if staff is immune they won't expose immune-suppressed, severely ill, fragile patients to viruses that can be life-threatening. (Ex: employee has child in day care who develops chicken pox/or measles and exposes employee. Employee comes to work not knowing he/she is contagious with the illness before the rash or pox erupts).

To protect other staff – if an infected employee comes to work and exposes other staff, several exposures/infections can occur resulting in lengthy absences from work for numerous staff…staffing shortage.

Must be completed prior to start date:

1. Immunity to:

Rubella	positive titer or 1 documented dose
Rubeola	positive titer or 2 documented doses
Varicella	positive titer or 2 documented doses
Mumps	positive titer or 1 documented dose

2. Hepatitis B
   Documentation of immunization (series of three doses)
   OR
   documentation of titer
   OR
   signed declination

3. TB skin test
   Negative history: PPD's every 6 months (Consult Hospital Policy)
   (Kaiser Permamente: 2 PPD's done in past 24 months – one of which is within the past three months.)
   Positive history: Chest x-ray within past year (12 months).
   Documentation of the positive skin test.
   (If x-ray is over 12 months we may accept a surveillance form stating that the student is asymptomatic from the student's place of employment or physician).

PPlease note: Roster developed through collaborative efforts of the Central Valley Academic Service Partnership.

Student Placement Matrix — Appendix D

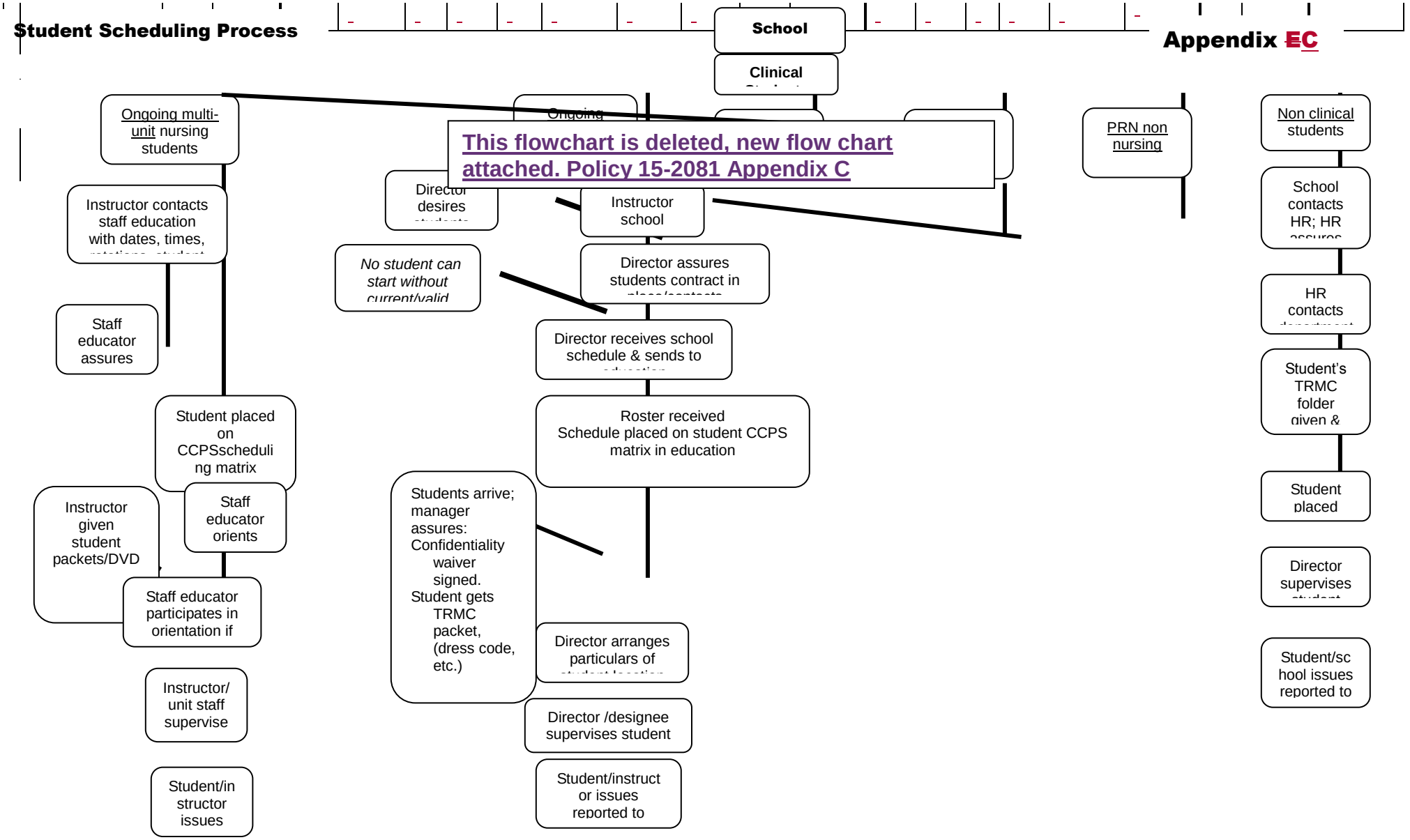
April 2012 Unit	ADC	Max Students	DAYS										PM's						NOC's		-
			SJVC LVN	Handford LVN	TAS LVN	TAS CNA	COS RN	Porterville LVN	High School	TCOVE	Paramedic	Total Students	COS RN	TAS LVN	TAS CNA	SJVC LVN	Paramedic	Total Students	COS RN	Total Students	Comments
RT	-	-	-	-	-	-	-	-	-	-	-	*2	-	-	-	-	-	-	-	-	-
Med Floor	20	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Surgical Floor	20	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	10	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ICU	8	6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

April 2012 Unit	ADC	MaxStudents	DAYS										PM's						NOC's		
			SJVC LVN	Handford LVN	TAS LVN	TAS CNA	COS RN	Porterville LVN	High School	TCOVE	Paramedic	Total Students	COS RN	TAS LVN	TAS CNA	SJVC LVN	Paramedic	Total Students	COS RN	Total Students	Comments
Cath Lab																					
Sunday																					
Monday																					
Tuesday																					
Wednesday																					
Thursday																					
Friday																					
Saturday																					
Post ICU																					
Sunday																					
Monday																					
Tuesday																					
Wednesday																					
Thursday																					
Friday																					
Saturday																					
ER		2																			
Sunday		2																			
Monday		2																			
Tuesday		2																			
Wednesday		2																			

April 2012 Unit	ADC	Max Students	DAYS										PM's						NOC's		-
			SJVC LVN	Handford LVN	TAS LVN	TAS CNA	COS RN	Porterville LVN	High School	TCOVE	Paramedic	Total Students	COS RN	TAS LVN	TAS CNA	SJVC LVN	Paramedic	Total Students	COS RN	Total Students	Comments
Fast Track	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Surgical	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
ACU	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	8	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
OR	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

April 2012 Unit	ADC	Max Students	DAYS										PM's						NOC's		-
			SJVC LVN	Handford LVN	TAS LVN	TAS CNA	COS RN	Porterville LVN	High School	TCOVE	Para medic	Total Students	COS RN	TAS LVN	TASCNA	SJVC LVN	Paramedic	Total Students	COS RN	Total Students	Comments
Recovery	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
OB	5	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-		-
Monday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Friday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Saturday	-	4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3rd Floor	5	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sunday	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monday	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tuesday	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wednesday	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Thursday	-	2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Student Scheduling Process **Appendix ~~E~~C**



STUDENT **SPONSORSHIP PROGRAM**
TULARE REGIONAL MEDICAL CENTER

SPONSORSHIP AGREEMENT

This Student Sponsorship Agreement ("Agreement") is entered into between _____ _____("EMPLOYEE") and Tulare Regional Medical Center ("TRMC") this _____ day of _____, 20__.

I. Purpose

The Student Sponsorship Program is part of Tulare Regional Medical Center's ("TRMC") recruitment, retention, and career development plan for regular full- and part-time employees. The Program offers paid release time for staff while enrolled in an accredited post-secondary education program in exchange for a commitment to continue working for TRMC after completion of the specified program. Sponsored employees will work up to 20 hours per week and receive up to 20 hours of matching elective training time for each week spent in class.

This Agreement does not modify EMPLOYEE's at-will employment status with TRMC.

III. SPONSORED EMPLOYEE RESPONSIBILITIES

A. EMPLOYEE is knowledgeable about and agrees to all relevant criteria and requirements set forth in the accompanying policy # 15-2013.1 Student Affiliations, Sponsorship, and Internships, Section II, Student Sponsorship Agreement.

B. EMPLOYEE has enrolled in an accredited educational institution named: _____, to pursue the following educational program _____.

C. EMPLOYEE agrees to accept any tax consequences which result from the Student Sponsorship Program.

D. EMPLOYEE expects to successfully complete the educational program specified in Section II.B on or before _____(month/year).

E. Should this Agreement be terminated prior to EMPLOYEE's successful completion of the Student Sponsorship Program, EMPLOYEE agrees to return to

regular work hours as scheduled for EMPLOYEE's position at the time the Agreement is terminated, excluding those EMPLOYEES who entered the Agreement as Student Interns.

F. EMPLOYEE passes his/her certification and/or licensure within six months after completion of his/her educational program.

G. EMPLOYEE agrees to continue working for TRMC after successful completion of the specified program for a period of not less than two years.

IV. TRMC RESPONSIBILITIES

A. TRMC agrees to provide EMPLOYEE paid release time while enrolled in an accredited post-secondary education program; this is done in exchange for EMPLOYEE's commitment to continue working for TRMC after completion of the specified program

B. TRMC agrees to abide by the terms set forth in accompanying Policy 15-2013.1, Student Affiliations, Sponsorship, and Internships, Section II, Student Sponsorship Agreement.

IV. TERMINATION

A. This Agreement may be terminated by either party upon ten (10) days written notice to the other, due to a party breaching its obligations as specified in this Agreement and accompanying Policy 15-2013.1.

B. TRMC reserves the right to terminate and/or modify this Agreement, in writing, in order to provide the necessary level of care to its patients and/or changes in availability of funding. In such a situation, TRMC may, in its sole discretion, elect to release EMPLOYEE from the obligations of this Agreement.

V. This is a loan that must be repaid. It may be repaid in one of two ways:

A. EMPLOYEE remains employed at TRMC after the successful completion of the course of study and receipt of licensure for a period of two years per the terms of this Agreement. At the end of that period, the loan is considered discharged (forgiven). EMPLOYEE accepts resulting tax consequences, if any.

NOTE: *The obligation to remain employed for a period of two years is contingent upon the availability of FT or PT positions in EMPLOYEE's scope of practice or work unit. If, following completion of the course of study and receipt of licensure, there are no available positions in EMPLOYEE's newly acquired scope of practice or work unit at TRMC, EMPLOYEE will have the right to*

seek employment elsewhere and shall be released from the aforementioned obligation.

B. EMPLOYEE "buys out" (either voluntarily or involuntarily, depending on the reason for termination of the Agreement) the loan by repaying the amount TRMC paid for hours EMPLOYEE was engaged in her/his educational program and not actually working as an employee in the job description in which she/he was employed while in the Student Sponsorship Program.

My signature acknowledges that I understand the terms of this Agreement, its conditions and attached Policy and agree to abide by them.

CEO	date	Employee	date
Dept. Mgr. / Director	date	H.R. Director	date

POLICY / GUIDELINE

~~**STUDENT SPONSORSHIP MATRIX**~~
~~**Appendix G**~~

~~EMPLOYEE~~	~~PROGRAM~~	~~DEPT~~	~~DATE APPROVED~~	~~FINISH DATE~~	~~PAPERWORK~~	~~SCHOOL~~
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Descriptive Name: Student Affiliations and Sponsorships

Descriptive Type: Revised~~New~~ Policy~~-~~

Document Number: 15-2081

Attachments: 3~~7~~ - (Appendix A – C~~G~~)

Author: ~~Melissa Janes/~~Carol Bradford

Typist: ~~Jennifer Bridges~~

Creation Date: 03/09/2012

Revision Date: 01/18/18

Prev. Dist. Date: ~~None~~04/26/12

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~04/25/12~~	

Effective Date: ~~04/26/12~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments: Sponsorship removed 8/4/17

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Breastfeeding - Friendly Workplace Policy

I. Purpose:

To establish guidelines for promoting a breastfeeding-friendly work environment at Tulare Regional Medical Center.

II. Policy:

A. Tulare Regional Medical Center (TRMC) recognizes that human milk is the optimal food for growth and development of infants and TRMC encourages employees and management to have a positive, accepting attitude toward working women and breastfeeding. TRMC promotes and supports breastfeeding and the expression of human milk by employees who are breastfeeding when they return to work. It shall be the policy of TRMC to provide:

1. Breaks:

a. Employees are entitled to breaks for lactation. Break times shall be established based on the employee's work schedule. If possible the lactation break is to run concurrently with any break time already provided.

b. For non-exempt employees, lactation time beyond the regular paid rest break time is unpaid. At management discretion, beginning or ending work times may be adjusted to accommodate these breaks.

2. Lactation Space:

a. Appropriate private space shall be provided with reasonable efforts made for the location to be in close proximity to the nursing employees' work area. The space should be equipped with an electrical outlet and comfortable seating. TRMC has a

Lactation Services room on the 3rd floor of the hospital adjacent to the nurses' station.

b. The location may be the place where the nursing mother normally works if there is adequate privacy (e.g., the employee's office, a supervisor's private office, or a conference room that can be secured).

c. Areas such as restrooms, closets or storage rooms are usually not appropriate spaces for lactation purposes. However, a separate anteroom (women's lounge) or a separate changing area within or next to a bathroom may be permissible. Closets or storage rooms that do not contain noxious materials may be converted to be acceptable private spaces assuming they have adequate ventilation.

d. For non-office sites, the employee, the supervisor and the Human Resources Department should enter into a good faith interactive process to identify reasonable accommodations.

3. Communication:

1. A copy of this policy shall be provided to every employee upon adoption, at new employee orientations, and to an employee prior to a maternity or FMLA leave.

2. This policy shall be posted in the employee handbook and on the Tulare Regional Medical Center Human Resources Internet/Intranet page.

III. Procedure:

A. To request reasonable accommodations for lactation, an affected employee shall advise her supervisor and the human resources department of her request either verbally or in writing, ideally maternity leave for existing employees, and upon hire for new employees currently needing lactation accommodation.

B. Supervisors and the human resources department who receive a request for reasonable accommodations for lactation will review the request and prepare to make accommodations in a timely manner that does not interfere with lactation.

IV. Employee Benefits:

A. Employees should contact their individual healthcare insurance company for lactation benefits covered.

B. Employees should be aware that breast pumps are deductible under IRS CODE §213(d).

V. References:

Federal Law:

1. Patient Protection and Affordable Care Act (P.L. 111- 148, 2010) amended 29 USC 207 of the Fair Labor Standards Act (FLSA) to require employers to provide reasonable break time for nursing mothers, but applies only to employees who are not exempt from the overtime pay requirements of the FLSA (i.e., classified employees). http://www.dol.gov/whd/nursingmothers/ Breastfeeding Support, Services & Supplies are mandated under health care reform: http://www.hrsa.gov/womensguidelines/

2. EEOC vs. Houston Funding II, LLC 5th Circuit Federal Court of Appeals Holds that Lactation Discrimination is Sex Discrimination under Title VII. http://www.eeoc.gov/eeoc/newsroom/release/5-31-13a.cfm

California State Law:

1. Labor Code 1030-1033 applies to all employees. California law preempts Federal Law, therefore all California employees are covered. Furthermore, pursuant to Labor Code 1033, violation of Labor Code 1030-1033 may result in a citation from the Labor Commissioner and/or a civil penalty. http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=01001-02000&file=1030-1033

2. Fair Employment and Housing Act defines “sex” to include breastfeeding, and in DFEH v. Acosta Tacos, termination of a breastfeeding employee constituted sex discrimination, because “breastfeeding is an activity intrinsic to females”. Lactation is listed as an “other related medical condition” of pregnancy in Pregnancy. Disability Regulations. http://www.dfeh.ca.gov/Publications_FEHADescr.htm

3. Dept. Fair Empl. & Hous. v. Acosta Tacos (June 16, 2009) No. 09-03-P, FEHC Precedential Decs. 2009 [2009 WL 2595487 (Cal.F.E.H.C.)]. http://www.dfeh.ca.gov/res/docs/FEHC%20Pregnancy%20Regs/FINAL_APPROVED_PREG_REGS_CLEAN_11_30_12.pdf

4. The Business Case for Breastfeeding: Return on investment is $3 to $1, in health care cost savings, reduced absenteeism and increased productivity retention. Breaks are predictable, absences aren’t. http://www.womenshealth.gov/breastfeeding/government-in-action/business-case-for-breastfeeding/

5. IRS CODE § 213(d) allows you to deduct the costs of durable medical equipment to support lactation. http://www.irs.gov/pub/irs-pdf/p502.pdf

Please consult your legal counsel before you deny an employee a lactation accommodation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Breastfeeding – Friendly Workplace Policy

Descriptive Type: ~~New Policy~~Revised

Document Number: 15-2083

Attachments: None

Author: Tammy Kegler~~Brooke Brown~~

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 03/31/14

Revision Date: 01/31/18

Prev. Dist. Date: 08/26/14~~None~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~08/25/14~~	

Effective Date: ~~08/26/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: All Departments and TLHCD~~HS~~ Medical Staff

FROM: Administration

SUBJECT: Safe Medical Device Reporting

I. PURPOSE

It is the policy of TLHCD~~HS~~ to report all deaths, serious illness and injuries of any magnitude resulting from the malfunction of a medical device to the FDA and the manufacturer of the device in accordance with the requirements of the Safe Medical Device Act of 1990, hereafter referred to as the "Act".

II. SCOPE

This policy applies to any medical personnel who discover, witness or are notified of a suspected medical device incident. This includes physicians, nurses, technicians, therapists or other medical personnel who use or operate medical devices.

III. DEFINITIONS

Serious illness or injury as defined by the Act is an illness or injury that is life threatening, or results in permanent impairment of a bodily function, or results in permanent damage to a bodily structure, or necessitates immediate medical or surgical intervention to prevent permanent impairment of a bodily function or permanent damage to a bodily structure.

Medical device as defined by the Act is any instrument, apparatus, or other article that is used to prevent, diagnose, mitigate, or treat a disease or to affect the structure or function of the body, with the exception of drugs. A medical device could be something as simple as a tongue blade or as complex as a surgical laser. It includes but is not limited to, ventilators, monitors, dialyzers, implants, syringes, invitro diagnostic kits, reagents and most disposable patient care supplies.

Any employee that obtains information from any source that reasonably suggests that a device has or may have “caused or contributed” to the death or serious injury of a patient or employee, must report this incident immediately to the Performance Improvement Office or Nursing Supervisor if after hours. (“Cause or contributed” is defined to mean that a death or serious injury was or may have been attributed to a medical device, or that a medical device was or may have been a factor in a death or serious injury.)

Board of Directors: 3/27/02
REPORTING REQUIREMENTS

Any medical personnel who discovers, witnesses, or is notified of a medical device incident that he or she suspects to have caused a death, serious illness or injury to a patient shall immediately notify the attending physician, and complete a Quality Review Report at the time of the incident detailing the events that occurred, including the occurrences that may be the result of user error.
The Quality Review Report will include the following information:

A. Patient's Name

B. Room and Bed #

C. Physician Name

D. Product Name

E. Location of the Product

F. Serial # of the product (if available)

G. Model or product re-order # (if available)

H. Name of the manufacturer (if available)

I. Brief description of the incident

The attending physician shall examine the patient, evaluate the severity of the illness or injury related to the incident, and document in the patient's progress notes the patient's physical findings, and any action taken based on the examination.

IV. INVESTIGATION OF THE INCIDENT

Within twenty-four (24) hours of being notified of a suspected medical device incident, the Performance Improvement Office or the Nursing Supervisor if after hours will conduct an investigation. Along with the Performance Improvement Office or Nursing Supervisor, the Safe Medical Device Team will determine the appropriate corrective action or educational requirements for staff to correct the issue. The Safe Medical Device Team will, using the Medical device Incident Investigation Form, submit its findings and recommendations to Administration.

V. SUBMISSION OF ADVERSE MEDICAL DEVICE INCIDENT REPORTS

Administration will within ten (10) days of the incident submit a FDA MedWatch Form #3500A. (Attached to policy).

VI. SEMI-ANNUAL REPORTS

On January 1 and July 1 of each year a summary of all adverse medical device reports will be submitted to the FDA on FDA Form #3419 by Administration. The summary will include:

A. NAME OF HOSPITAL
B. NAME OF DEVICE
C. SS#
D. MODEL#
E. MANUFACTURER NAME AND ADDRESS
F. BRIEF DESCRIPTION OF EVENTS

VII. DISCLAIMER

TLHCD assumes no responsibility for injury, death or illness due to the malfunction of any medical device resulting from manufacturing defects and/or design.

VIII. RESPONSIBILITY

The Safe Medical Device Team consisting of the Hospital Safety Officer, Risk Manager, Materials Manager and Designee from the Performance Improvement Office and/or Nursing Supervisor, shall develop, publish, and maintain the forms, instructions and procedures necessary for implementation of this policy.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Safe Medical Device Reporting

Descriptive Type: Revised

Document Number: 16-1006

Attachments: None

Author: ~~Julie Gresham~~

Typist: ~~Debra Campbell~~Carol Bradford

Creation Date: 12/31/01

Revision Date: 01/16/18

Prev. Dist. Date: ~~2/12/97~~

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors		

Effective Date: ~~3/28/02~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Materials Management and Medical Staff

FROM: Administration

SUBJECT: Loaning of Hospital Goods to Physicians or Physician Groups

POLICY:

No employee of Tulare Regional Medical Center shall loan any hospital equipment, surgical instruments or supplies to any physician or physician group without prior written authorization from the CEO of the District.

Failure to follow this directive shall result in disciplinary action to the employee, up to and including termination, as well as reporting of the physician to medical executive committee.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Loaning of Goods by Physicians or Physician Groups
Descriptive Type:	Revised
Document Number:	16-1009
Attachments:	None
Author:	Delbert Bryant
Typist:	~~Melissa Arend~~Carol Bradford
Creation Date:	10/27/04
Revision Date:	01~~2~~/17~~09~~/18~~5~~
Prev. Dist. Date:	04/23/09

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Purchasing of Goods and Services – Invoice Approval and Processing

I. POLICY:

1. Materials Management is responsible for coordinating all aspects of goods and services purchases. To provide uniform processing and approval, all departments must adhere to the procedures of this policy.

2. The purpose of this policy is to establish the responsibilities and authorization limits for the procurement of capital expenditures, inventory and non-inventory items.

3. The approval rights and limits for the purchase include authorization of inventory levels and approval of vendor prices. Purchases are commitments of the hospital funds and, therefore, all purchases must be approved by authorized representatives of the Hospital.

II. PURCHASE ORDER:

1. The following departments are the only departments authorized by Administration to spend, or commit to spend, Hospital funds for goods and services and issue appropriate purchases ordered for routine hospital purchases.

DEPARTMENT	**PURCHASE AUTHORITY**
Materials Management	All goods, services, and equipment
Dietary	Food and food related goods. For items that the hospital is responsible for, the department must submit a Purchase

Effective Date: ( ) (Department Name) (Policy Name)

APPROVED:

Medical Executive Comm.:

Board Of Directors:

Order (PO) and follow normal hospital policy).

Maintenance	Building and equipment supply parts. For items that the hospital is responsible for, the department must submit a Purchase Order (PO) and follow normal hospital policy).
Pharmacy	Pharmaceuticals and I.V. Solutions

2. All departments requesting the purchase of any goods and services must complete a requisition form with the required information and forward to the appropriate signatory authority as described in each section below.

3. Exception for PO:

   A. In the event of an emergency, expenses related to direct patient care are approved to be ordered without a PO. However, the requesting department should contact their immediate supervisor or administrator on call to notify of the purchase, preferably via e-mail. This practice should be an exception and the rule. It is the responsibility of the requesting employee to complete the PO after the emergency purchase within 24 hours.

4. The Materials Management Director (or equivalent person performing this function) will verify all of the necessary purchasing information and approvals, determine the appropriate vendor (if necessary), obtain competitive quotes from preferred vendors (as deemed necessary), issue the purchase order and follow-up on the receipt of the item purchased.

5. On non-PO invoices, all disbursements must be supported by one or more of the following documents:

   A. Original Vendor invoice or check request form.

   B. Sufficient support to identify and justify the expenditure.

   C. Any payments to a physician (including medical groups) must be supported by the “Payment to Physician Check Request” and requires BOTH the CFO’s and Compliance Officer’s signatures for payment.

6. Purchase orders are NOT generally required for routine and recurring payments such as utility bills, consulting fees, professional dues, registry services, advertising, lease payments, subscriptions and reimbursable

expenses. **However, all contracts must have either the CFO/COO or the CEO's signature.**

7. Authorization and Signatory Limits: Non-Inventory and Non-Capital Expenditure items:

   A. The authorization limit for Department Directors is not more than $250.00.

   B. Amounts over $250.00 require the signature of the Senior Manager on the requisition.

   C. Amounts over $2,500.00 require signature of the CFO/COO.

   D. Amounts over $10,000.00 require the signature of the CEO.

8. All purchases are accumulated in the financial records and compared to the financial budget for fiscal control. Any anticipated purchases exceeding budget require the written approval of the CFO/COO.

9. General Inventory Requirements:

   A. Maintain a certain level of material on hand in inventory which is considered reasonable and provides for the hospital's ability to take advantage of the purchase of quantity discounts. The decision to establish the quantity to purchase must be based on the judgment of the Department Director and Materials Management Director based on the analysis of the inventory usage reports.

10. Responsibilities:

    A. Purchase Order for Materials:

       1. The Materials Management Director, or designee, will issue a purchase order for all of the material items purchased and it must be fully documented with the pertinent information for the order. The Materials Management Director is not authorized to purchase items of any personal nature, even if there are authorized signatures and the person requesting it indicated that they would reimburse the Hospital. The purchase order must be signed by the Materials Management Director and any deviation from the standard terms agreed upon with the vendor must be documented in writing and approved by the appropriate authority. The Materials Management Director must keep the

purchase orders in a sequential control accounting for both, used, unused and voided documents.

2. Purchase Order for Services:

The process for the purchase order with services is the same as with materials, however, a service agreement must also be attached to the order for verification. The terms and conditions for both the delivery and payment of the services must be consistent with the Hospital's Vendor Terms Policy.

3. Competitive Bids:

The Materials Management Director must obtain or have obtained a reasonable number of competitive bids from preferred vendors to ensure the hospital is receiving an appropriate price. The analysis should also consider other factors such as quality or a non-price service differentiator.

11. Purchase Order Distribution:

A. Materials Management is responsible to distribute copies of the purchase orders and at a minimum:

1. Vendor receives a copy.

2. Materials Management Director receives a copy that should be maintained in a permanent file in alphabetical sequence by vendor.

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III. INVOICE APPROVAL:

1. Only original invoices, which have been properly approved by authorized personnel, should be accepted as support for disbursement. An original invoice may be received electronically and therefore appear similar to a photocopy. Duplicate entry of invoices shall be prevented via system fail safes and staff diligence.

2. Invoices for goods and services must reference the purchase order number that relates to those items ordered and billed. Any invoice that does not indicate the hospital purchase order number shall be annotated manually with the purchase order number.

3. Invoices must be approved for payment by the Department Director under whose purchase authority the purchase order was issued.

4. Invoices must be matched with the purchase order and any applicable receiving documents (i.e., packing slip, freight bill, etc.). In practice this is done electronically using the system. Each non-PO invoice must indicate the appropriate general ledger account number prior to forwarding to accounting for payment process.

5. Check requests should only be used in situations where a supporting invoice is not available (i.e., rent, interest payments, etc.).

6. Each invoice or check request must be stamped with a date stamp when received by the Accounts Payable Department.

7. Once a check has been signed and paid, the invoice shall be scanned and filed electronically with all supporting documentation.

8. The CFO or designee shall approve the Accounts Payable check register before checks are released.

9. Authorization and Signatures for Capital Expenditures:

    A. Refer to the “Capital Expenditure Policy” for the authority purchase of capital expenditures.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name:	Purchasing of Goods and Services – Invoice Approval and Processing
Descriptive Type:	Revised
Document Number:	16-4002
Attachments:	None
Author:	~~Delbert Bryant/Troy Salazar~~Celeste Terronez
Typist:	Melissa Arend
Creation Date:	01/24/02
Revision Date:	~~12/11/15~~1/17/18
Prev. Dist. Date:	04/23/09

Committee Review and Approval:	Approval Date:	Comments:
Board of Directors	~~12/23/15~~	

Effective Date:	~~12/24/15~~
Forward To:	Policy Binders (PBX and Administration) and Post to Intranet
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

DELETE

TO: Medical Staff/Clinical Services

FROM: Administration

SUBJECT: Standardized Procedure - Discharge of Patients from Ambulatory Care Unit by an R.N.

I. POLICY

A. Function:
To insure the safe discharge of patients in the Ambulatory Care Unit (ACU) by a qualified R.N.

B. Circumstances:
Outpatient surgical and procedure patients may be discharged by an R.N. using established criteria. No supervision will be required.

II. PROTOCOL

A. Data Base:
A written/verbal/telephone order to discharge per criteria will be obtained from the attending physician. The patient must meet all discharge criteria.

B. Action:

I. Obtain order from attending physician.

II. Document discharge criteria have been met.

a. Vital Signs Stable

1. The documented BP is within 20mm/hg of the admitting BP.

2. Respirations are unlabored and patient is able to deep breathe and cough freely.

3. Skin color is normal - there is no evidence of pallor, dusky or jaundiced skin.

b. Swallow, cough and gag reflex present.

c. Able to ambulate - or activity tolerance has returned to admitting level.

d. Nausea, vomiting, dizziness minimal. The physician will be notified if the patient is actively vomiting.

e. Absence of respiratory distress.

f. Alert and oriented or LOC returned to admitting level.

g. Post anesthesia recovery score of 8-10.

h. Dressings are dry and intact or with minimal pink or red drainage.

i. Patient's pain has been controlled with use of oral pain medications and documented in narrative notes.

j. Orthostatically Stable.

III. In the event, the discharge criteria have not been met, the patient status will be communicated to the physician.

IV. Discharge Instructions will be given to the patient which cover the following:

a. Postoperative care.

b. Follow-up appointment.

c. How to access care if an emergency arises in the post-operative period.

C. Record Keeping:

I. Complete ACU operative day report. Describe in narrative notes care given and outcome. Describe education provided to patient/family. List name/relationship of person responsible for patient at discharge.

II. Complete individualized discharge instructions. Forward copy of discharge instructions to physician generated by medical records.

D. R.N. Requirements

I. Ongoing Evaluation: Annual completion of R.N. skills checklist and annual performance appraisal with review of R.N. documentation.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Standardized Procedure – Discharge of Patients from Ambulatory Care Unit by an R.N.

Descriptive Type: Revised Policy

Document Number: 20-20,002

Attachments: None

Author: Andrea White

Typist: ~~Julie Gresham~~ Carol Bradford

Creation Date: 01/07/13

Revision Date: 3/20/18

Prev. Dist. Date: 10/23/08

Committee Review and Approval:	Approval Date:	Comments:
Interdisciplinary Committee	04/22/13	
Surgery Service Committee	08/28/13	
MEC	02/12/14	
Board of Directors	02/26/14	

Effective Date: 02/27/14

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Medical Staff/Clinical Services

FROM: Administration

SUBJECT: Standardized Procedure - Discharge of Post-Operative/Post-Procedural Patients from Medical/ Surgical/ Ambulatory Care Units by a R.N.

POLICY

A. Function
To insure the safe discharge of patients in the medical-surgical units by a qualified R.N.

B. Circumstances
Medical-surgical patients may be discharged by a R.N. using the following established criteria.

PROTOCOL

A. Data Base
A written/verbal/telephone order to discharge per criteria will be obtained from the attending physician. The patient must meet all discharge criteria.

B. Action

I. Obtain order from attending physician.

II. Document discharge criteria have been met.

a. Vital Signs Stable

1. The documented BP is within 20mm of the admitting BP and a systolic blood pressure of 85mm or above. (Orthostatically Satable)

2. Respirations are unlabored and patient is able to deep breathe and cough freely.

3. Skin color is normal for patient - there is no evidence of pallor or dusky skin.

b. Swallow and gag reflex present.

c. Able to ambulate - or activity tolerance has returned to admitting level.

d. Nausea and vomiting minimal. The physician will be notified if the patient is actively vomiting.

e. Alert and oriented or LOC returned to admitting level.

f. Dressings are dry and intact or with minimal pink or red drainage.

g. Patient's pain has been assessed and addressed prior to discharge and documented in focus notes. Patient's pain medication given at least 30 minutes prior to discharge.

h. Post anesthesia recovery score of 8-10.

III. In the event, the discharge criteria have not been met; the patient status will be communicated to the physician.

IV. Discharge Instructions will be given to the patient which cover the following:

a. Post-operative/post-procedural care.

b. Follow-up appointment.

c. How to access care if an emergency arises in the post-operative/post-procedural period.

C. Record Keeping

I. Initial Assessment Admission – Electronic Medical Record

II. Focus notes/Vital Sign – Electronic Medical Record

III. ~~Interdisciplinary~~ Patient/Family Education – Electronic Medical Record ~~(IPER)~~

IV. Individualized discharge instructions/List name and relationship of person responsible for patient at discharge. Forward copy of discharge instructions to physician generated by Electronic Medical Record.

V. Medication Administration – Electronic Medical Record (as appropriate)

VI. Complete ACU operative day report/care given, outcomes in Electronic Medical Record.

D. R.N. Requirements

I. Education, Training, and Experiences: California R.N. license and BLS.

II. Initial Evaluation: Demonstration of competency by completion of Medical-Surgical/Ambulatory Care Unit RN CAT and RN/ACU skills checklist.

III. Ongoing Evaluation: Annual completion of RN skills checklist and annual performance appraisal.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Standardized Procedure – Discharge of Post-Operative/Post Procedural Patients from Medical/Surgical Units by a R.N.
Descriptive Type:	Revised Policy
Document Number:	20-20,006
Attachments:	None
Author:	Angie Graziano
Typist:	~~Julie Gresham~~Carol Bradford/Andrea Carrasco/Ena Menezes
Creation Date:	01/07/05
Revision Date:	03/05/18
Prev. Dist. Date:	10/23/08

Committee Review and Approval:	Approval Date:	Comments:
Interdisciplinary Committee	~~04/22/13~~	
Surgery Service Committee	~~08/28/13~~	
MEC	~~02/12/14~~	
Board of Directors	~~02/26/14~~	

Effective Date:	~~02/27/14~~
Forward To:	Policy Binders – (PBX and Administration) and Post to Intranet Site
Disposition:	Copy and Distribution - Administration
Comments:	

TULARE DISTRICT HOSPITAL

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff

FROM: Administration

SUBJECT: Standardized Procedure – Protocol Order for Treatment of Burns

I. POLICY

It is the Policy of Tulare District Hospital to provide a mechanism for the immediate treatment of patients who sustain burn injuries. The ED nurse will provide emergency treatment according to the following procedure in order to limit the extent of damage and maintain optimal patient comfort and homeostasis.

II. PROCEDURE

A. Patient will be taken to the treatment area ASAP.

B. Supplemental high-flow 02 shall be given if there is a history of:

1. Smoke inhalation or entrapment in a closed space.

2. Evidence of burns about the face (i.e., singed hair, etc.).

C. All patients with history of electrical shock/burns will be placed on a cardiac monitor.

D. <u>Small to moderate burn</u>:

1. Gather the appropriate supplies:

a. Sterile towels
b. Sterile water or saline to cool and/or flush burns
c. Irrigation syringe and water basin
d. Ice

2. Cool burn surface with iced saline X 30 minutes or irrigate if a chemical burn; if ice is used, there shall be no contact of ice to the skin.

3. Contact EDMD re: pain control, if needed.

E. Moderate to large burn area:

1. Patient shall be taken directly to a critical care room.

2. Sterile burn linens shall be placed on gurney to minimize risk of infection.

3. ED MD will be notified.

4. ABC's shall be assessed immediately

5. Intravenous therapy with Normal saline (1000cc) shall be infused at a rapid rate if:

   a. Patient has full thickness (3rd degree) area greater than 10% of body surface.

   b. Partial thickness greater than 20%.

   c. Rate calculation for fluid replacement within first 24 hours:

      2 to 4 ml x kg x % of TBSA burned

      Of this calculated amount, one half should be infused in the first eight hours post burn. The 24 hour period begins from the time of the actual burn, not the time of arrival to the ED.

      Infuse the second half over the next 16 hours.

      Please reference attached "Modified Lund and Browder Chart" to determine percentage of TBSA burned.

6. Pain control as needed

7. Maintain normal body temperature

a. If prolonged ED treatment of major burn, assess rectal temp every 15 minutes.
b. If temperature falls below 97.6 degrees, any cooling measures shall be stopped.

c. If feasible, cover unaffected areas of body with warm blankets to maintain homeostasis.

If patient receives any diagnostic test per protocol and subsequently leaves the ED without being seen by a physician or physicians assistant, he/she will be processed as an AMA rather than a LWBS.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Standardized Procedure – Protocol Order for Treatment of Burns
Descriptive Type:	~~Revised~~ Delete Policy
Document Number:	20-20,010
Attachments:	None
Author:	Susan Morris
Typist:	Julie Gresham
Creation Date:	11/01/06
Prev. Dist. Date:	04/23/06
Revision Notes:	E&O 11/15/06 Interdisciplinary Committee 11/08/06 MEC 11/0806 General Board 11/29/06
Effective Date:	11/30/06
Forward To:	Policy Binders – 5 – Post on Intranet site
Disposition:	Copy and Distribution – Administration
Comments:	

Policy # 20-20,010

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Medical Staff, Clinical Services

FROM: Administration

SUBJECT: Standardized Procedure: Protocol for Obtaining Glucose Finger Sticks

A patient's glucose status can change rapidly and time is of the essence in beginning treatment for hypo/hyperglycemia.

The following procedure for obtaining glucose finger sticks is established for all clinical areas of the Hospital:

1. A RN may determine to do a chemstick when the patient is exhibiting symptoms of Hyperglycemia/Hypoglycemia i.e., Hyperglycemia - extreme thirst, frequent urination, dry itchy skin, hunger, blurred vision, drowsiness, decreased healing or Hypoglycemia - diaphoretic, shaking, fast heartbeat, dizziness anxious, hunger, impaired vision, weakness fatigue, headache, irritability.

2. A RN may perform a chemstick when the Laboratory glucose value does not match the value anticipated by the RN.

3. The results of the chemstick must be called to the attending physician immediately.

4. The chemstick report must be noted with the time, date, name of physician notified and the signature of LVN or RN that notified the physician.

5. Suspected or known diabetics that are scheduled for a procedure / surgery will have a chemstick performed prior to the procedure. The results will be documented in the electronic medical record~~charted on the proper form~~ and the attending physician will be notified if levels are not within the normal ranges of blood glucose. The chemstick will be repeated prior to discharge.

Questions concerning any aspect of this policy/guideline should be referred to Administration.
This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Effective Date: ~~09/25/08~~

APPROVED:

Medical Executive Comm.: ~~09/10/08~~

Board of Directors: ~~09/24/08~~

(20) Clinical Services
Standardized Procedures:
Protocol for Obtaining Glucose Finger Sticks
20-20,015

Descriptive Name: Standardized Procedure: Protocol for Obtaining Glucose Finger Sticks

Descriptive Type: Revised Policy

Document Number: 20-20,015

Attachments: None

Author: Andrea White

Typist: ~~Hillary Keith~~Carol Bradford

Creation Date: 04/01/06

Revision Date: 01/17/18

Prev. Dist. Date: ~~05/25/06~~

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	~~09/03/08~~	
E&O Committee	~~09/03/08~~	
Interdisciplinary Committee	~~09/08/08~~	
MEC	~~09/10/08~~	
Board of Directors	~~09/24/08~~	

Effective Date: ~~09/25/08~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure - Weak and Dizzy Protocol

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of weakness and dizziness may have specific procedures initiated by an Emergency Department RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention for patients presenting to the ED with signs and symptoms of weakness and dizziness.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure:
Weak and Dizzy Protocol
Approved: 20-20,017

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
WEAK AND DIZZY PROTOCOL

Ask About:

- Syncope (fainting)
- Difficulty Walking
- Bleeding – type, onset
- Prior Hx of cardiac problems
- Alteration in sensation
- Onset of symptoms; precipitated by:
  - Fever
  - Focal Weakness
  - Medication

Evaluate for:

- ♦ Nuero (obvious deficits)
  - ♦ Pupils
  - ♦ Hand grip
  - ♦ Difficulty ambulating
  - ♦ Facial droop
  - ♦ Vertigo v. Ataxia
- ♦ Abnormal BP
- ♦ Cardiac finding (irregular pulse)
- ♦ Metabolic (i.e. Diabetes)
- ♦ Bleeding

CATEGORIZE AS:

I. EMERGENT

- ♦ Loss of ambulatory status
- ♦ Chest discomfort/cardiac symptoms (See Cardiac)
- ♦ Unstable vital signs
- ♦ Headache with neuro findings
- ♦ Active bleeding (See bleeding)
- ♦ Bloody or black stools (See Bleeding)

ORDERS

- ♦ MD evaluation immediately
- ♦ 0^2 and SaO^2 Monitoring
- ♦ IV Normal Saline 20ml/hr
- ♦ Cardiac Monitor
- ♦ CBC, Renal Panel
- ♦ Med Levels
- ♦ UA
- ♦ EKG
- ♦ CXR
- ♦ Consider Cardiac Panel

II. URGENT

- ♦ New onset weakness/dizziness
- ♦ Age 45 years or older
- ♦ Bloody or black stools (See Bleeding)
- ♦ Stable vital signs
- ♦ TIA suspected

ORDERS

- ♦ IV Normal Saline @ 20ml/hr
- ♦ 0^2 and SaO^2 Monitoring
- ♦ Cardiac Monitor
- ♦ CBC, Renal Panel
- ♦ Med Levels
- ♦ UA
- ♦ EKG

III. SEMI & NON-URGENT

- ♦ Stable Vitals

ORDERS

NONE

#20-20,017

Descriptive Name: Standardized Procedure – Weak and Dizzy Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,017

Attachments: Weak and Dizzy Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: Emergency Department staff and Medical Staff

FROM: Administration

DELETE

SUBJECT: Standardized Procedure – Bleeding Protocol

POLICY:

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of bleeding may have specific procedures initiated by an Emergency Department RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention for patients presenting to the ED with signs and symptoms of bleeding.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
BLEEDING PROTOCOL

Ask About:

- Onset
- Duration
- Location
- Amount
- Color
- Pain
- Medications
  - Anticoagulation
  - Anti Platelets

Evaluate for:

- Postural blood pressure changes
- Current, active bleeding
- Associated problems

CATEGORIZE AS:

I. EMERGENT

- Epistaxis with Hypertension
- Wound (See Laceration)
- Vaginal (See OB/GYN Protocol)
- GI (See Abdominal Protocol)
- Hypotension
- Tachycardia

ORDERS

- MD evaluation immediately
- CBC
- Renal Panel
- PT/PTT
- Type and Cross
- IV 0.9% Normal Saline 150ml/hr
- O^2 / Pulse Oximetry
- Cardiac Monitor

II. URGENT

- Inability to control bleeding with triage intervention

ORDERS

- CBC
- Renal Panel
- PT/PTT
- **Put in comments**: "Draw extra tube for possible cross match"

III. SEMI & NON-URGENT

- Stable Vitals

ORDERS

NONE

#20-20,018

Descriptive Name: Standardized Procedure – Bleeding Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,018

Attachments: Bleeding Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

DELETE

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – OB/GYN Protocol

POLICY:

Patients presenting to the Emergency Department with Obstetric or Gynecological symptoms may have specific procedures initiated by an Emergency Department RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention for patients presenting to the ED with Obstetric or Gynecological symptoms.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: OB/GYN Protocol 20-20,019

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
GYN/OB PROTOCOL

Ask About:

- GR ___ P ___ AB ___ Ectopic ___ LMP___
- Abdominal Pain Severity
- Vaginal bleeding
  - Onset and activity at onset
  - Number of pads used per hour
  - Passage of clots or tissues
- Vaginal discharge
- Last sexual contact

Evaluate for:

- ♦ Hemodynamic instability

CATEGORIZE AS:

I. EMERGENT

- ♦ Abnormal and unstable vital signs (Systolic BP < 100 or > 170, RR > 30, HR > 110)
- ♦ Vaginal bleeding with unstable vital signs
- ♦ Severe pain
- ♦ Imminent delivery

II. URGENT

- ♦ Mild to moderate vaginal bleeding with stable vital signs
- ♦ Vaginal discharge with fever and/or mild to moderate abdominal pain

III. SEMI & NON-URGENT

- ♦ Mild vaginal bleeding
- ♦ No abdominal pain
- ♦ Vaginal discharge without fever

ORDERS

- ♦ MD evaluation immediately
- ♦ UA (catheterization if actively bleeding)
- ♦ Urine HCG, Serum HCG if unable to void
- ♦ See Bleeding Protocol (Vaginal) for orders
- ♦ Renal Panel
- ♦ Type and Rh
- ♦ IV 0.9% Normal Saline 100ml/hr
- ♦ DIC panel for 3rd Trimester and Trauma
- ♦ If pregnant greater than 20 weeks with abdominal pain and/or bleeding, go directly to L&D

ORDERS

- ♦ UA (catheterization if actively bleeding)
- ♦ Urine HCG, Serum HCG if unable to void
- ♦ See Bleeding Protocol
- ♦ Type and Cross Match

ORDERS

- ♦ Urine HCG, Serum HCG if unable to void
- ♦ UA (catheterization if actively bleeding)

#20-20,019

Descriptive Name: Standardized Procedure – OB/GYN Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,019

Attachments: OB/GYN Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: ~~Julie Gresham~~Carol Bradford

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

DELETE

SUBJECT: Standardized Procedure – Laceration Protocol

POLICY:

Patients presenting to the Emergency Department with Laceration(s) may have specific procedures initiated by an ED RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention for patients presenting to the ED with Laceration(s).

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure:
Laceration Protocol
Approved: 20-20,020

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
LACERATION PROTOCOL

Ask About:

- Tetanus status
- Time and Date of injury
- Mechanism
- Loss of function and/or sensory changes
  - ♦ Bleeding controlled

Evaluate for:

- ♦ Visualize the wound
  - ♦ Location
  - ♦ Size (approx. in cm)
  - ♦ Distal pulse – present/absent
  - ♦ Possible foreign body in wound

CATEGORIZE AS:

I. EMERGENT

- ♦ Unable to control bleeding
- ♦ Amputation
- ♦ Impaled object
- ♦ Active bleeding with unstable vital signs
- ♦ Neuro/vascular comprise

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/hr
- ♦ Control bleeding (See Bleeding)
- ♦ X-ray if suspected fracture, Foreign Body (wounds caused by broken glass) or associated amputation (See Fractures and Sprains)
- ♦ Give Tdap vaccine IM, if indicated
- ♦ Cefazolin 1 gm IV, if no allergy
  - Pediatrics refer to antibiotic dosing index
- ♦ Suture tray at bedside

II. URGENT

- ♦ Bleeding controlled with direct pressure
- ♦ Avulsions
- ♦ Animal or human bite
- ♦ Neuro/vascular intact

ORDERS

- ♦ LET for abrasions with limited surface area
- ♦ Suture tray at bedside, if indicated
  - ♦ Control bleeding (See Bleeding, if indicated)
  - ♦ X-ray if suspected fracture, Foreign Body (wounds caused by broken glass) or associated amputation (See Fractures and Sprains
- ♦ Give Tdap vaccine IM, if indicated

III. SEMI & NON-URGENT

- ♦ No active bleeding
- ♦ Puncture wound
- ♦ Laceration > 24 hours without bleeding
- ♦ Superficial laceration / abrasion
- ♦ No signs of infection, erythema, red streaking

ORDERS

- ♦ X-ray if suspected fracture, Foreign Body (wounds caused by broken glass) or associated amputation (See Fractures and Sprains)
- ♦ Suture tray at bedside
- ♦ Give Tdap vaccine IM, if indicated

Descriptive Name: Standardized Procedure – Laceration Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,020

Attachments: Laceration Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

DELETE

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Respiratory Distress – Pediatric Upper Airway

POLICY:

Pediatric patients presenting to the Emergency Department with signs and symptoms of Respiratory Distress may have specific procedures initiated by an ED RN or RCP prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of pediatric patients presenting to the ED in Respiratory Distress.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Respiratory Distress – Pediatric Upper Airway Protocol 20-20,021

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
RESPIRATORY DISTRESS
PEDIATRIC UPPER AIRWAY PROTOCOL

Ask About:

- Time of onset
- Possible foreign body aspiration
- Associated symptoms:
  - Cough, Fever, Vomiting, Taking liquids
- Prior History:
  Asthma, Bronchitis, Pneumonia, Prematurity, Other
- Treatment PTA: MDI, antitussive, decongestant, antibiotic, other

Evaluate for:

- ♦ Temperature
- ♦ Tachycardia
- ♦ Respiratory Rate
- ♦ Hydration status

CATEGORIZE AS:

I. EMERGENT

- ♦ Stridor/drooling
- ♦ Nasal flaring
- ♦ Intercostal retractions
- ♦ Sniff position
- ♦ Muffled voice/cry
- ♦ Cyanotic
- ♦ Poor eye contact
- ♦ RR > 60/min, Pulse > 130/min, Temp > 103ºF
- ♦ Pulse Oximetry < 95%

ORDERS

- ♦ MD evaluation immediately
- ♦ RT evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/hr
- ♦ O^2 to keep SaO^2 > 95%
- ♦ See Fever Protocol
- ♦ Chest X-ray Portable
- ♦ Albuterol Nebulizer Treatment (For Wheezing)
- ♦ Racemic Epinephrine Nebulizer Treatment (For Croup/Stridor)

II. URGENT

- ♦ Mild nasal flaring
- ♦ Mild intercostals retractions
- ♦ Mild audible wheezing
- ♦ RR < 60/min
- ♦ Pulse rate < 130/min
- ♦ Pulse Oximetry SaO^2 > 95%
- ♦ Temp < 103ºF

ORDERS

- ♦ MD evaluation immediately
- ♦ RT evaluation immediately
- ♦ Pulse Oximetry
- ♦ See Fever Protocol
- ♦ Albuterol Nebulizer treatment (For Wheezing)
- ♦ Racemic Epinephrine Nebulizer Treatment (For Croup/Stridor)

III. SEMI & NON-URGENT

- ♦ Healthy appearing
- ♦ No Emergent or Urgent Symptoms
- ♦ Eye contact/active
- ♦ Stuffy nose/eating poorly
- ♦ Afebrile

ORDERS

- ♦ Pulse Oximetry SaO^2 monitoring

#20-20,021

Descriptive Name: Standardized Procedure – Respiratory Distress – Pediatric Upper Airway Protocol

Descriptive Type: ~~New~~Delete ~~-~~Policy

Document Number: 20-20,021

Attachments: Respiratory Distress – Pediatric Upper Airway Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Vomiting and Diarrhea Under 3 Years

POLICY:

Pediatric patients presenting to the Emergency Department with signs and symptoms of vomiting and diarrhea in children under 3 years old may have specific procedures initiated by an ED RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients under 3 years old presenting to the ED with vomiting and diarrhea.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Vomiting and Diarrhea Under 3 Years Protocol 20-20,022

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE DISTRICT HOSPITAL
POLICY/GUIDELINE MANUAL
VOMITING AND DIARRHEA
UNDER 3 YEARS PROTOCOL

Ask About:

- Frequency (how many / how often)
- Onset of illness
- Taking fluids
- Last oral intake
- Number of diapers changed (time interval)
- Recognized parents; poorly, good
- Treatment prior to arrival
- Precipitated by:
  - Others ill or ill contacts

Evaluate for:

- ♦ Tachycardia
- ♦ Hydration status
- ♦ Interest in taking fluids

CATEGORIZE AS:

I. EMERGENT

- ♦ Tachycardia
- ♦ Fever (See Fever Protocol)
- ♦ Weak cry
- ♦ Poor skin turgor
- ♦ Poor eye contact
- ♦ Dry mucous membranes

II. URGENT

- ♦ Active vomiting at triage
- ♦ Presence of fever (See Fever Protocol)
- ♦ No urine output in 6 hours

III. SEMI & NON-URGENT

- ♦ Vomiting less than 2 PTA
- ♦ Tolerating fluids at home
- ♦ Normal vitals

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/kg IV Bolus, then 20ml/hr
- ♦ Rectal swab / Culture and Sensitivity / Hemoccult
- ♦ Urine catheterization if not bathroom trained
- ♦ Pulse Oximetry monitoring
- ♦ CBC, Renal Panel
- ♦ Monitor

ORDERS

- ♦ MD evaluation immediately
- ♦ Rectal swab (send only at MD instructions)
- ♦ Urine catheterization if not bathroom trained
- ♦ Pulse Oximetry
- ♦ CBC, Renal Panel
- ♦ Trial of oral fluids, give 1-2 teaspoons every 10 minutes, as tolerated

ORDERS

- ♦ Trial of oral fluids
- ♦ Save diaper for sample

Descriptive Name: Standardized Procedure – Vomiting and Diarrhea Under 3 Years Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,022

Attachments: Vomiting and Diarrhea Under 3 Years Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Respiratory Distress – Adult Protocol

POLICY:

Adult patients presenting to the Emergency Department with signs and symptoms of Respiratory Distress may have specific procedures initiated by an ED RN or RCP prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of adult patients presenting to the ED in Respiratory Distress.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Respiratory Distress – Adult Protocol 20-20,023

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
RESPIRATORY DISTRESS
ADULT PROTOCOL

Ask About:

- Duration of illness
- Onset
- Cough
- Sputum or phlegm
- Fever
- Degree of dyspnea (at rest v. exertion v. lying)
- Edema of legs, new or worsening
- Prior hx: asthma, COPD, emphysema, PE, CHF, DM, other tx prior to arrival
- Current medications "for breathing"
- Smoking Hx

Evaluate for:

- ♦ Skin color
- ♦ Skin moisture
- ♦ Ability to speak
- ♦ Chest pain (See Cardiac Protocol)

CATEGORIZE AS:

I. EMERGENT

- ♦ Dyspnea with conversation
- ♦ 1-2 word sentences
- ♦ Audible wheezing/rales
- ♦ Tripod position
- ♦ Altered level of consciousness
- ♦ Accessory muscle use
- ♦ Cyanosis and abnormal "skin vitals"
- ♦ Pulse Oximetry < 90%
- ♦ Fever (See Fever Protocol)
- ♦ RR > 30/min
- ♦ HR > 120/min

ORDERS

- ♦ MD evaluation immediately
- ♦ Airway management
- ♦ Cardiac Monitor
- ♦ IV 0.9% Normal Saline 20ml/hr
- ♦ EKG

II. URGENT

- ♦ Fever (See Fever Protocol)
- ♦ Pain with inspiration (pleuritic)
- ♦ 4-5 word sentences
- ♦ Moderate respiratory distress

ORDERS

- ♦ MD evaluation immediately
- ♦ Pulse Oximetry
- ♦ CBC
- ♦ Panel 12
- ♦ Medication levels

III. SEMI & NON-URGENT

- ♦ Productive cough
- ♦ Able to speak in full sentences
- ♦ Normal vitals

ORDERS

- ♦ Pulse Oximetry
- ♦ Chest X-ray
- ♦ Collect Sputum

#20-20,023

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
RESPIRATORY DISTRESS
ADULT

CATEGORIZE AS:

I. EMERGENT | **II. URGENT** | **III. SEMI & NON-URGENT**

ORDERS

- Pulse Oximetry
- Breathing treatment
- CBC, Panel 12, Medication Levels, PT, PTT Cardiac Enzymes, BNP
- **Blood Cultures and Early Antibiotics**
- **Collect Sputum for C&S**
- Portable Chest X-ray
- Intubation set up
- Initiate Chest Pain Protocol

ORDERS

- **Blood Cultures and Early Antibiotics**
- **Collect Sputum for C&S**
- Breathing Treatment
- Chest X-ray, 2 view when possible

#20-20,023

Descriptive Name: Standardized Procedure – Respiratory Distress - Adult Protocol

Descriptive Type: ~~New~~Delete Policy

Document Number: 20-20,023

Attachments: Respiratory Distress – Adult Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Abdominal Pain Protocol

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of Abdominal Pain may have specific procedures initiated by an ED RN or prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients presenting to the ED with Abdominal Pain.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Abdominal Pain Protocol 20-20,024

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
ABDOMINAL PAIN PROTOCOL

Ask About:

- Time, date and activity of onset
- Location and severity
- Radiation of pain
- Constant, intermittent, cramping, sharp, dull
- Vomiting, diarrhea, nausea, fever, flatulent
- Urinary symptoms
- Last BM
- Last meal and liquids
- Any Abdominal Hx

Evaluate for:

- ♦ Sitting and standing BP and Pulse
- ♦ Cardiac origin (See Chest Pain Protocol)
- ♦ Chest pain (See Cardiac Protocol)

CATEGORIZE AS:

I. EMERGENT

- ♦ Fever (See Fever Protocol)
- ♦ Severe pain
- ♦ BP Systolic < 100, Pulse > 110, RR > 30/min
- ♦ Vomiting blood or blood from rectum
- ♦ Post partum less than 4 weeks
- ♦ Abdominal pain radiating to the back
- ♦ Pregnant along with emergent criteria (OB/GYN Protocol)

ORDERS

- ♦ MD evaluation immediately
- ♦ CBC, Panel-12, UA
- ♦ Urine HCG, Serum HCG if unable to void
- ♦ Collect stool
- ♦ Ask MD regarding CT Abdomin and use of contrast

II. URGENT

- ♦ Normal vital signs for age
- ♦ Moderate pain
- ♦ Vomiting and diarrhea (active)
- ♦ Hx tarry stools or black stools

ORDERS

- ♦ MD evaluation immediately
- ♦ CBC, Panel-12, UA
- ♦ Lipase / Amylase
- ♦ Urine HCG, Serum HCG if unable to void
- ♦ Collect stool

III. SEMI & NON-URGENT

- ♦ Normal vital signs for age
- ♦ Mild pain (pt tolerates pain well)
- ♦ No vomiting in past 6 hours
- ♦ Dysuria, frequency
- ♦ Urethral discharge with mild abdominal pain

ORDERS

- ♦ UA
- ♦ Urine HCG, Serum HCG if unable to void

#20-20,024

Descriptive Name: Standardized Procedure – Abdominal Pain Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,024

Attachments: Abdominal Pain Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Allergic Reaction Protocol

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of Allergic Reaction may have specific procedures initiated by an ED RN or RCP prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients presenting to the ED with signs and symptoms of an allergic reaction.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure:
Allergic Reaction Protocol
Approved: 20-20,025

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
ALLERGIC REACTION PROTOCOL

Ask About:

- Onset (Time and place of incident)
- Precipitating agent or event
- Prior episodes
- Last meal

Evaluate for:

- Skin color
- Size of swelling
- Mechanism (e.g., insect bite)
- Difficulty breathing
- Known sensitivity

CATEGORIZE AS:

I. EMERGENT

- Stridor (Upper airway comprise)
- Wheezing (lower airway distress)
- Swollen tongue
- Hx of previous anaphylaxis
- Unstable / abnormal vital signs (systolic BP < 100, Pulse > 110/min, RR > 24/min)
- Moderate or severe facial swelling
- Throat tightness

ORDERS

- MD evaluation immediately
- RT evaluation immediately
- IV 0.9% Normal Saline 20ml/hr
- Adults - Give Benadryl 25mg IV
- Pediatrics – Give Benadryl 1mg/kg IV
- Prepare Epinephrine
- Oxygen, Pulse Oximetry
- Cardiac Monitor
- Have Airway/Trach kit at bedside

II. URGENT

- Hives for < 12 hours
- Mild facial swelling
- Peri-orbital swelling
- Joint swelling

ORDERS

- MD evaluation immediately
- RT evaluation immediately
- Saline Lock
- Pulse Oximetry
- Adults - Give Benadryl 50mg PO
- Pediatric – Give Benadryl of 1mg/kg IV

III. SEMI & NON-URGENT

- Rash
- Chronic rash < 1 week
- Localized swelling
- Hives present > 12-24 hours

ORDERS

NONE

#20-20,025

Descriptive Name: Standardized Procedure – Allergic Reaction Protocol

Descriptive Type: ~~New~~Delete Policy

Document Number: 20-20,025

Attachments: Allergic Reaction Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Fractures and Sprains Protocol

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of fractures and sprains may have specific procedures initiated by an ED RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients presenting to the ED with fractures and sprains.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Fractures and Sprains Protocol 20-20,026

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
FRACTURES AND SPRAINS PROTOCOL

Ask About:

- Location
- Time and Date of injury
- Mechanism of injury

Evaluate for:

- Swelling
- Bony point tenderness
- Distal pulse
- Sensation
- Able to walk after injury
- Severity of pain

CATEGORIZE AS:

I. EMERGENT

- Severe pain
- Deformity
- Neuro/vascular compromised
- Dislocation other than finger/toe

ORDERS

- MD evaluation immediately
- IV 0.9% Normal Saline 20ml/hr
- Immobilization affected extremity
- Elevation
- Ice
- See Pain Protocol (as per MD orders)
- Order X-ray (include joint above and below injury), if traumatic

II. URGENT

- Moderate pain
- Neuro/vascular intact
- Unable to bear weight

ORDERS

- MD evaluation immediately
- Saline Lock
- Immobilization affected extremity
- Elevation
- Ice
- See Pain Protocol (as per MD orders)
- Order X-ray (include joint above and below injury), if traumatic

III. SEMI & NON-URGENT

- Mild
- Full weight bearing
- Full ROM
- Intact neuro/vascular
- No swelling

ORDERS

- Order appropriate X-rays

#20-20,026

Descriptive Name: Standardized Procedure – Fractures and Sprains Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,026

Attachments: Allergic Reaction Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Fever I – 0-90 Days Old Protocol

POLICY:

Pediatric patients (0-90 days) presenting to the Emergency Department with signs and symptoms of a fever may have specific procedures initiated by an ED RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of pediatric patients (0-90 days) presenting to the ED with a fever.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL

FEVER I

0-90 DAYS OLD PROTOCOL

Ask About:

- Onset
- Temperature obtained at home and how (Rectal?)
- Exposure to others who are ill
- Birth Hx
- Prior Hx: Ear infections, febrile seizures, premature birth
- Tx prior to arrival

Evaluate for:

♦ All infants 0-90 days with a documented rectal temp > 100.3ºF are EMERGENT

CATEGORIZE AS:

I. EMERGENT

- ♦ Current of Hx of temp > 100.4ºF (Rectal in infants younger than 90 days)
- ♦ Febrile seizure
- ♦ Petechiae
- ♦ Listlessness / not attentive
- ♦ Poor eye contact
- ♦ Complicated birth Hx

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/kg IV bolus, then 20ml/hr
- ♦ Pulse Oximetry
- ♦ Consult physician for treatment of fever
- ♦ CBC, Renal Panel, Blood Cultures, CRP
- ♦ Cath UA, and C&S
- ♦ Chest X-ray, if URI or Respiratory symptoms present
- ♦ Consent for LP (Prepare form)
- ♦ I&O

II. URGENT

- ♦ Sickle cell disease
- ♦ Immunocompromise
- ♦ Temp > 100.4

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/hr
- ♦ Pulse Oximetry
- ♦ I&O
- ♦ CBC, Blood Cultures, CRP
- ♦ Cath UA and C/S

III. SEMI & NON-URGENT

- ♦ Normal rectal temp
- ♦ Good eye contact
- ♦ Child “looks good”
- ♦ Feeding and sucking well

ORDERS

NONE

#20-20,027

Descriptive Name: Standardized Procedure – Fever I – 0-90 Days Old Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,027

Attachments: Fever I – 0-90 Days Old Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE DISTRICT HOSPITAL

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Fever II – 3 Months to 36 Months Protocol

POLICY:

Pediatric patients (3 months to 36 months) presenting to the Emergency Department with signs and symptoms of a fever may have specific procedures initiated by an ED RN prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of pediatric patients (3 months to 36 months) presenting to the ED with a fever.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Fever II – 3 Months to 36 Months Protocol 20-20,028

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL

FEVER II

3 MONTHS TO 36 MONTHS PROTOCOL

Ask About:

- Onset
- Temperature obtained at home and how (Rectal?)
- Exposure to others who are ill
- Birth Hx
- Prior Hx: Ear infections, febrile seizures, premature birth
- Tx prior to arrival

Evaluate for:

- ♦ Temp > 103ºF (Rectal)
- ♦ Interest in liquids
- ♦ Quality of sucking

CATEGORIZE AS:

I. EMERGENT

- ♦ Current of Hx of temp > 103ºF, rectal in infants older than 3 months and:
  - ♦ Febrile seizure
  - ♦ Petechiae
  - ♦ Listlessness / not attentive
  - ♦ Poor eye contact
  - ♦ Toxic looking

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20 ml/kg as IV bolus, then 20ml/hr
- ♦ Acetaminophen 15mg/kg orally, if unable to tolerate oral, then rectally **OR** **I**buprofen 10mg/kg orally, if received acetaminophen within prior 4 hours
- ♦ Pulse Oximetry
- ♦ I&O
- ♦ Cath UA, males up to one year and females up to 3 years
- ♦ CBC, Renal Panel, Blood Cultures, CRP, UA and C&S
- ♦ Chest X-ray if pulse Oximetry < 95% and/or Hx of cough, URI or if Respiratory Symptoms present
- ♦ Consent for LP (Prepare form)

II. URGENT

- ♦ Current of Hx of temp > 103ºF, rectal in infants older than 3 months and:
  - ♦ Sickle cell disease
  - ♦ Immunocompromise
  - ♦ Other chronic disease (i.e., Diabetes)

ORDERS

- ♦ MD evaluation immediately
- ♦ IV 0.9% Normal Saline 20ml/hr
- ♦ Acetaminophen 15mg/kg orally, if unable to tolerate oral, then rectally **OR** **I**buprofen 10mg/kg orally, if received acetaminophen within prior 4 hours
- ♦ Pulse Oximetry
- ♦ I&O
- ♦ Cath UA, males up to one year and females up to 3 years
- ♦ CBC, Renal Panel, Blood Cultures, CRP, UA and C&S
- ♦ Chest X-ray if pulse Oximetry < 95% and/or Hx of cough

III. SEMI & NON-URGENT

- ♦ Normal rectal temp
- ♦ Good eye contact
- ♦ Child “looks good”
- ♦ Feeding and sucking well

ORDERS

NONE

#20-20,028

Descriptive Name: Standardized Procedure – Fever II – 3 Months to 36 Months Protocol

Descriptive Type: ~~New~~Delete Policy

Document Number: 20-20,028

Attachments: Fever II – 3 Months to 36 Months Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

POLICY/GUIDELINE MANUAL

DELETE

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Chest Pain and Anginal Equivalents Protocol

POLICY:

Patients presenting to the Emergency Department with signs and symptoms of Chest Pain or Angina may have specific procedures initiated by an ED RN or prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients presenting to the ED with Chest Pain or Angina.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure: Chest Pain or Anginal Equivalents Protocol 20-20,029

Approved:

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
CHEST PAIN AND ANGINAL EQUIVALENTS PROTOCOL

Ask About:

- Pain description and Onset Time and Nature
- Pain scale 1-10
- Prior Hx of Cardiac Disease
- Risk Factors (HTN, DM, Elevated Cholesterol, family history)
- Dyspnea and associated symptoms
- Use of Cocaine / Amphetamines
- Medications – **Coumadin, Viagra, Cialis**
- **Aspirin Use and When**
- **Beta Blockers Use and When**
- Upper back pain
- Epigastric Abdominal Pain
- Upper Extremity Pain Non-Traumatic Ache-Dull
- Shortness of Breath with or without Chest or Back Pain
- Syncope or Near Syncope
- Diaphoresis
- Palpitations – Brady or Tachycardia
- Choking Sensations
- Weakness and/or Lightheadedness – Dizziness

Evaluate for:

- Hemodynamic instability
- Diaphoresis
- Hypoxia
- Abnormal pulse
- Abnormal lung sounds, i.e., crackles, wheezes

CATEGORIZE AS:

I. EMERGENT

- Classic angina (pressure type chest pain, squeezing in nature
- Atypical CP in patent 45 or older with Hx of Acute Coronary Syndrome or significant risk factor
- Use of cardiac stimulants, i.e., Cocaine/Amphetamines
- Unstable vital signs (BP < 100/60, or > 150/100, Pulse < 60 or > 100)
- Diaphoresis
- Shortness of breath
- SaO^2 < 95% on RA
- Recent Hx of PCI or CABG

ORDERS

- MD face to face evaluation immediately
- Saline lock
- O^2 to keep SaO^2 > 95%

II. URGENT

- Recent typical or atypical angina chest pain, **now resolved**
- Hx of Acute Coronary Syndrome
- Use of cardiac stimulants, i.e., Cocaine or Amphetamines
- Stable vitals
- SaO^2 > 95% on RA
- Normal lung sounds

ORDERS

- MD evaluation immediately
- Saline lock
- EKG within 10 min

III. SEMI & NON-URGENT

- Atypical, sharp, chest pain in patient less than 30 y/o
- SaO^2 > 95% on RA
- Normal vital signs
- No shortness of breath
- No use of cardiac stimulants, i.e., Cocaine or Amphetamines
- No Hx of heart disease
- Normal lung exam

ORDERS

- Cardiac monitor
- EKG
- Chest X-ray

#20-20,029

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
CHEST PAIN AND ANGINAL EQUIVALENTS PROTOCOL

CATEGORIZE AS:

I. EMERGENT | **II. URGENT** | **III. SEMI & NON-URGENT**

ORDERS

- Cardiac monitor
- CBC, Panel 12, Medication Levels, PT, PTT Cardiac Enzymes, BNP
- Nitroglycerin 0.4mg sublingual every 5 minutes up to three doses. Hold if pain free or BP < 100/60
- Portable Chest X-ray
- Intubation set up
- Initiate Chest Pain Protocol

ORDERS

- **Aspirin 325mg orally – hold if allergic**
- Portable Chest X-ray
- CBC, Panel 12, Cardiac Enzymes, Medication levels, PT, PTT, BNP

#20-20,029

Descriptive Name: Standardized Procedure – Chest Pain and Anginal Equivalents Protocol

Descriptive Type: ~~New~~Delete Policy

Document Number: 20-20,029

Attachments: Chest Pain and Anginal Equivalents Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT

DELETE

POLICY/GUIDELINE MANUAL

TO: Emergency Department Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure – Pain Management Protocol

POLICY:

Patients presenting to the Emergency Department with complaints of pain may have specific procedures initiated by an ED RN or prior to being seen by the ED physician or PA/NP.

PURPOSE:

To provide a mechanism for immediate intervention of patients presenting to the ED with pain.

PROCEDURE:

See attached protocol.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 09/25/08 (20) Standardized Procedure:
Pain Management Protocol
Approved: 20-20,030

Medical Executive Comm.: 09/10/08

Board of Directors: 09/24/08

TULARE LOCAL HEALTH CARE DISTRICT
POLICY/GUIDELINE MANUAL
PAIN MANAGEMENT PROTOCOL

INITIATION OF PAIN PROTOCOL PATIENT MUST BE UNDER THE DIRECT OBSERVATION OF A RN OR LVN

Ask About:

- Sudden vs. gradual onset
- Time of day
- Activity at time of onset
- Prior history
- Location
- Radiation
- Provoking or alleviating factors – severity and duration

Evaluate for:

- Vital signs
- Pallor
- Diaphoresis
- Posture and body pattern, gait
- Facial expression

CATEGORIZE AS:

I. EMERGENT

- Pain associated with any other "emergent" condition or complaint by location, cause, severity (i.e., Chest pain)
- Subjective severity of 8-10 pain scale and abnormal vital signs
- MD evaluation immediately

II. URGENT

- Normal vital signs
- Subjective distress of 4-7 pain scale

III. SEMI & NON-URGENT

- Normal vitals
- No other complaint or condition of an urgent or emergent type
- Pt tolerating pain well with subjective severity of 0-3 pain scale

MD Orders (written or verbal)

If verbal document V.O. per MD and time

Morphine Pain Protocol "Morphine": Ages 3 years and older and less than 65 years

- First dose: **0.05 mg/kg of IV Morphine Sulfate****
- Second dose: **0.05 mg/kg of IV Morphine Sulfate, 7 minutes after first dose****
- Third dose: **0.05 mg/kg of IV Morphine Sulfate, 7 minutes after second dose****

***May repeat until:*

- Pt states pain is relieved
- Pt refuses more medication
- Pt is asleep or respiratory rate at or < 12/min
- Drop in systolic BP of 20mmHG or more…or systolic pressure < 120

Hydromorphone - Dilaudid Pain Protocol "Dilaudid": Ages 3 years and older and less than 65 years

- Initial Dose: 0.01mg/kg of Hydromorphone (Dilaudid) IV**
- Subsequent does: Hydromorphone (Dilaudid) 0.01 mg/kg IV every 15 minutes**

***May repeat until:*

- Pt states pain is relieved
- Pt refuses more medication
- Pt is asleep or respiratory rate at or < 12/min
- Drop in systolic BP of 20mmHG or more…or systolic pressure < 120

Descriptive Name: Standardized Procedure – Pain Management Protocol Protocol

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,030

Attachments: Pain Management Protocol

Author: Val M. Warhaft, M.D. / Chief Medical Officer

Typist: Julie Gresham

Creation Date: 09/03/08

Previous Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
P&T Committee	09/03/08	
E&O Committee	09/03/08	
Interdisciplinary Committee	09/08/08	
MEC	09/10/08	
Board of Directors	09/24/08	

Effective Date: 09/25/08

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments:

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: Rural Health Clinic Staff, Laboratory and Medical Staff

FROM: Administration

SUBJECT: Standard Procedure – Finger Stick Hemoglobin Testing in the Rural Health Clinic

PURPOSE:

To provide the Rural Health Clinic's (RHC) health care providers with important routine patient information efficiently.

POLICY:

1. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse will routinely perform Finger Stick Hemoglobin Testing for all known pregnant patients at each visit.

2. Finger Stick Hemoglobin testing results must be documented in the medical record per the RHC CLIA policy guidelines for the provider to review at the time of examination with the time, date, and the signature of Medical Assistant, Licensed Vocational Nurse or Registered Nurse who performed the test.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Standardized Procedure – Finger Stick Hemoglobin Testing in the Rural Health Clinic
Descriptive Type:	~~New~~ Delete Policy
Document Number:	20-20,033
Attachments:	None
Author:	Carol Thiel, RN, NP
Typist:	Julie Gresham
Creation Date:	04/14/09
Previous Dist. Date:	None

Committee Review:	Approval Date:	Comments:
Interdisciplinary Committee	05/11/2009	
MEC	05/13/2009	
Board of Directors	05/27/2009	

Effective Date:	05/28/2009
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Dr. Kamboj has approved this policy.

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: Rural Health Clinic Staff, Laboratory and Medical Staff

FROM: Administration

SUBJECT: Standard Procedure – Urine Dip Testing in the Rural Health Clinic

PURPOSE:

To provide the Rural Health Clinic's (RHC) health care providers with important routine patient information efficiently.

POLICY:

1. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse may determine to perform Urine Dip testing when the patient offers chief complaints of dysuria or low abdominal pain, or flank pain with other symptoms or pyelonephritis (chills, headache, costrovertebral angle tenderness and possible hematuria).

2. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse will routinely perform Urine Dip testing for post partum and all OB visits.

3. The Urine dip testing results must be documented in the medical record per the RHC CLIA policy guidelines for the provider to review at the time of examination with the time, date, and the signature of the Medical Assistant, Licensed Vocational Nurse or Registered Nurse who performed the test.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 05/28/09 (20) Clinical Services

Standardized Procedure: Urine Dip Testing in the Rural Health Clinic 20-20,034

APPROVED:

Medical Executive Comm.: 05/13/09

Board of Directors: 05/27/09

Descriptive Name:	Standardized Procedure – Urine Dip Testing in the Rural Health Clinic
Descriptive Type:	~~New~~ Delete Policy
Document Number:	20-20,034
Attachments:	None
Author:	Carol Thiel, RN, NP
Typist:	Julie Gresham
Creation Date:	04/14/09
Previous Dist. Date:	None

Committee Review:	Approval Date:	Comments:
Interdisciplinary Committee	05/11/2009	
MEC	05/13/2009	
Board of Directors	05/27/2009	

Effective Date:	05/28/09
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Dr. Kamboj approved this policy.

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: Rural Health Clinic Staff, Laboratory and Medical Staff

FROM: Administration

SUBJECT: Standard Procedure – Finger Stick Glucose Testing in the Rural Health Clinic

PURPOSE:

To provide the Rural Health Clinic's (RHC) health care providers with important routine patient information efficiently.

POLICY:

1. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse may determine to do a finger stick glucose testing when the patient is exhibiting symptoms of Hyperglycemia/Hypoglycemia, i.e.:

   A. Hyperglycemia – extreme thirst, frequent urination, dry itchy skin, hunger, blurred vision, drowsiness, decreased healing or;

   B. Hypoglycemia – diaphoretic, shaking, fast heartbeat, dizziness, anxious, hunger, impaired vision, weakness, fatigue, headache, irritability.

2. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse may perform a finger stick glucose test when the Laboratory glucose value does not match the value anticipated by the Medical Assistant, Licensed Vocational Nurse or Registered Nurse.

3. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse will routinely perform finger stick glucose testing for all known diabetics during the vital sign process before the provider examines the patient.

4. The finger stick glucose testing results must be documented per RHC CLIA policy guidelines in the medical record for the provider to review at the time of examination with the time, date, and the signature of Medical Assistant, Licensed Vocational Nurse or Registered Nurse who performed the test.

5. Suspected or known diabetics that are scheduled for a procedure will have finger

stick glucose testing performed prior to any procedure. The results will be charted on the proper form and the attending physician will be notified if levels are not within the normal ranges (70 -150 mg/dl) of blood glucose. The finger stick glucose testing will be repeated prior to discharge.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name:	Standardized Procedure – Finger Stick Glucose Testing in the Rural Health Clinic
Descriptive Type:	~~New~~ Delete Policy
Document Number:	20-20,035
Attachments:	None
Author:	Carol Thiel, RN, NP
Typist:	Julie Gresham
Creation Date:	04/14/09
Previous Dist. Date:	None

Committee Review:	Approval Date:	Comments:
Interdisciplinary Committee	05/11/2009	
MEC	05/13/2009	
Board of Directors	05/27/2009	

Effective Date:	05/28/09
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Dr. Kamboj approved this policy.

TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: Rural Health Clinic Staff, Laboratory and Medical Staff

FROM: Administration

SUBJECT: Standard Procedure – Urine Pregnancy Testing in the Rural Health Clinic

PURPOSE:

To provide the Rural Health Clinic's (RHC) health care providers with important routine patient information efficiently.

POLICY:

1. The following procedure for obtain Urine Pregnancy Testing is established for the Rural Health Clinics of the Hospital:

   A. A Medical Assistant, Licensed Vocational Nurse or Registered Nurse may determined to perform Urine Pregnancy Testing when the patient offers chief complaints of missed period/amenorrhea or abnormal menses or initial visit for those women requesting birth control.

   B. The Urine Pregnancy Testing results must be documented in the medical record for the provider to review at the time of examination with the time, date, and the signature of Medical Assistant, Licensed Vocational Nurse or Registered Nurse who performed the test.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Effective Date: 05/28/09 (20) Clinical Services
Standardized Procedure:
Finger Glucose Testing in the Rural Health Clinic
20-20,036

APPROVED:

Medical Executive Comm.: 05/13/09

Board of Directors: 05/27/09

Descriptive Name:	Standardized Procedure – Urine Pregnancy Testing in the Rural Health Clinic
Descriptive Type:	~~New~~ Delete Policy
Document Number:	20-20,036
Attachments:	None
Author:	Carol Thiel, RN, NP
Typist:	Julie Gresham
Creation Date:	04/14/09
Previous Dist. Date:	None

Committee Review:	Approval Date:	Comments:
Interdisciplinary Committee	05/11/2009	
MEC	05/13/2009	
Board of Directors	05/27/2009	

Effective Date:	05/28/2009
Forward To	Policy Binders – 5, Post on Intranet Site
Disposition:	Copy and Distribution – Administration
Comments:	Dr. Kamboj approved this policy.

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

DELETE

TO: Rural Health Clinic Staff and Medical Staff

FROM: Administration

SUBJECT: Standardized Procedure - Clinitek Status Urine Procedure in the Rural Health Clinic

PURPOSE;

Bayer Reagent Strip for urinalysis will be used for presumptive diagnosis of with at-risk patient groups to assist diagnosis in the following areas;

1. Kidney function
2. Urinary Tract infections
3. Carbohydrate metabolism
4. Liver function

POLICY:

This test will be used for presumptive diagnostic testing. The provider may choose to send the patient to the clinical laboratory for confirmatory testing.

Medical Assistants will be responsible for performing Clinitek Status Analyzer urine testing.

REAGENTS/MATERIALS:

Urine testing strips (Multistix 10 SG™)
Clinitek Status Analyzer
Paper for printing results
Instruction manual
Gloves
Paper towel
KOVA
NOTE: Never used expired supplies or reagents

PROCEDURE:

Collect urine in a clean container and test samples as soon as possible. If testing cannot be completed within one (1) hour after sample collection, **REFRIGERATE THE**

SPECIMEN IMMEDIATELY AND LET IT RETURN TO ROOM TEMPERATURE BEFORE

TESTING. Nitrite results are best optimized by using a first morning specimen or one which has incubated in the bladder for four (4) hours or more.

Press the "on/off" button. Follow the directions on the touch screen. Push the "strip test" area on the touch screen. The employee will enter their employee number when prompted to enter operator ID. The employee will then push the "enter new patient" area on the touch screen. The employee will then enter the patient name and account number. Remove the test strip and immediately reseal the container. Do not touch the test paper. Avoid exposing the strips to sunlight and moisture. Store the container between 4-30 degrees C (39-86 degrees F) in a dry place.

Completely immerse strip in **FRESH** urine and remove immediately to avoid dissolving out reagents.

When removing, run the edge of the strip against the rim of the urine container to remove excess urine. Hold the strip in a horizontal position to prevent mixing of chemicals from adjacent reagent areas and /or soiling of hands with urine. Blot the strip by touching the edge of the strip to the paper towel to remove excess urine. Place the reagent strip in the channel of the table with pads facing up. Slide the strip to the end of the table. Strip will automatically be pulled in the analyzer.

The Clinitek Status Analyzer will automatically perform a calibration test and then analyze the sample. Results will be automatically printed and displayed on the screen. The strip will be ejected from the Clinitek Status Analyzer and the employee will discard the strip in a biohazard container. The employee will touch the "done" area on the touch screen at the completion of the testing process.

Refer to the manufacturer's manual for more details regarding testing.

QUALITY CONTROL:

Staff will monitor expiration dates of supplies before use. Any and all supplies that are expired will not be used and will be discarded.

Performance of reagent strips should be confirmed by using the control solution to check validity of strip. Using the known positive and known negative controls, the results should be within the predetermined control range and recorded in the QC documentation/binder. The results will not be reported as "pass" or "fail" but will be reported as read on the actual strip. These results will be compared to the expected results and recorded.

In the event the test fails one or both of the internal controls, the staff will record the failure in the QC log and attempt to perform another test using a different test from the same kit.

If the second test fails, staff will notify the manager/director and healthcare provider. If appropriate technique is verified and the test does not demonstrate adequate control testing (positive or negative control testing), the patient will be referred to the TDH (or other lab at the patient's request) for testing.

The test failures will be recorded in the QC log and the remainder of the testing kit will be discarded. This will be recorded in the QC log as well. A new test kit box will be used for all future testing.

The known controls will be stored between 2º C and 8º C (35 – 46 degrees F). They will not be frozen. They will be dated when opened and discarded according to the expiration date on the bottle or per the manufacturer's recommendations or if the viability is questioned. The QC forms will include the lot and expiration date of the UA dip test strips as well as the control solutions.

Each day a urine dipstick test is ordered a QC test will be performed to demonstrate to be within range before performing the actual test.

The Clinitek Status Analyzer will perform an automatic calibration each time a test is run. If the Clinitek Status Analyzer fails to calibrate as expected, an error message will be displayed. Refer to the Troubleshooting guide. The employee will follow direction as stated in the manual. If this fails to correct the problem or if directed by the error message, the Clinical Director will be contacted. The faulty machine will be taken out of service until such time as it is repaired and in acceptable working order.

See the attached manufacturer's information and/or the manufacturer's manual.

DOCUMENTAION:

Lot number and expiration date of the testing material will be documented in the POC testing log and patient's medical record, along with the testing personnel's signature/date/time.

The employee will place the printed results in the patient's medical record for review.

EXPECTED VALUES:

Glucose……negative
Bilirubin……..negative
Ketone…….negative
Specific Gravity……<1.005->1.030
Occult blood…….negative
pH……..5.0->9.0
Protein…….negative
Urobilinogen…….3.2-16 umol/L
Nitrite……negative
Leukocytes…….negative
Albumin……..10-150 mmol/L
Creatinine……09.-26.5 mg/mmol
Albumin: Creatinine……<3.4 mg/mmol or normal
Protein Creatinine Multistix PRO….normal dilute/normal
Adult Males…….13.9-18.0 g/dl
Adult Female……11.0-16.0 g/dl
Infant after neonatal period…….10.0-14.0 g/dl

ABNORMAL VALUES:

Anything outside of the above parameters.

LIMITATIONS:

Limitations of testing are related to the Multistix 10 SG documented limitations. These are described in the manufacturer information insert located in the CLIA Manual of the clinics and product packing.

These include but are not limited to;

1. Decrease in leukocytes interpretation when glucose concentrations are > or = to 3 g/dL.
2. False negative results with absence of dietary nitrate, shortened bladder incubation, or the presence of nonreductive pathological microbes.

MAINTENANCE:

Disinfecting the test table will be performed as needed (with gross contamination) and not less than monthly. The test table will be removed per the manufacturer's manual and soaked in isopropyl alcohol for a time period of between 2 minutes to no longer than 10 minutes. The test table will be rinsed with water thoroughly, dried with a dry cloth and replaced in the machine.

The test strip table will be wiped with alcohol after each test where specimens have contaminated the side of the test strip cassette or/and table. It will be dried and replaced into the machine as stated above.

The employees will use a Sani-Cloth or an equivalent product to decontaminate the unit at least daily at the end of the working day.

Quality Control:

Quality Control will be performed on Multistix 10 SG strips as stated in the policy pertaining to urine dip stick testing. See that policy for more information.

REFERENCE:

Multistix 10 SG manufacturer's insert.
Clinitek Status Analyzer

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Standardized Procedure - Clinitek Status Urine Procedure

Descriptive Type: ~~New~~ Delete Policy

Document Number: 20-20,038

Attachments: None

Author: Carol Thiel

Typist: Julie Gresham

Creation Date: 08/24/09

Previous Dist. Date: None

Committee Review:	Approval Date:	Comments:
Interdisciplinary Committee	09/03/09	
MEC	09/09/09	
Board of Directors	09/23/09	

Effective Date: 09/23/09

Forward To Policy Binders – 5, Post on Intranet Site

Disposition: Copy and Distribution – Administration

Comments: Approved by Dr. Kamboj

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL

TO: Rural Clinic Staff and Medical Staff

FROM: Administration

SUBJECT: Physician Assistant/Nurse Practitioner Protocols/Guidelines for the Rural Health Department Affiliate Staff

I QUALIFICATIONS

1. Graduation from a school for Physician Assistants/Nurse Practitioners approved by the NCCPA or Board of Nursing respectively.

2. Certification from the NCCPA (National Commission on Certification of Physician Assistants). OR;

3. Current California License to practice as a professional Physician Assistant/Nurse Practitioners.

4. Current CPR card.

II. PREROGATIVES

1. To provide specified patient care services with examples being delineated in a privilege list to follow. The privilege list has been recommended by appropriate service chair, Medical Executive Committee and approved by the Board of Directors.

2. To complete a Provisional status of one (1) year, during which time the Physician Assistant/Nurse Practitioner will be observed by the Supervising Physician.

III. RESPONSIBILITIES:

1. **Physician Assistants'/Nurse Practitioner Responsibilities**:

   A. Participate in appropriate quality improvement monitoring and evaluation activities by attending the Family Practice and Outpatient Care Service Committee meetings.

Effective Date: ~~11/20/08~~

Physician Assistant/Nurse Practitioner
APPROVED:

Medical Executive Comm.: ~~11/12/08~~

Board of Directors: ~~11/19/08~~

(20) Clinical Guidelines
Family Practice:

Protocols/Guidelines for the Rural Health Department Affiliate Staff
20-1003

B. Abide by the medical staff bylaws, and all other rules, regulations, policies and procedures of the hospital and the medical staff.

C. Participate in Medical Staff assignments, committees or other functions as designated by the Chair of the Clinical Service, or the chief of staff.

D. Compare and complete in a timely manner all patient records for which care is provided.

2. **Certified Supervising Physician or Certified Designee responsibilities**:

A. Responsibility by a Physician currently appointed to the Active Medical Staff of the hospital with appropriate privileges to supervise the Physician Assistant/Nurse Practitioner. Pursuant to a written agreement, the physician(s) must:

B. Be continuously available either by telephone or in person to provide appropriate medical backup for consultation while the PA/NP is rendering patient care services.

C. Delegate to the PA/NP only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

D. Observe or review evidence of the PA/NP performance of all tasks and procedures to be delegated to the PA/NP until assured of competency.

E. Establish in writing transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the PA/NP's scope of practice for such times when a supervising physician is not on the premises.

F. Adopt and approve protocols to govern the performance of the PA/NP. Protocols will be referenced in the approved and disclosed texts. The supervising physician shall review, countersign, and date a minimum of 10% sample medical records of patients treated by the PA/NP within 30 days.

G. The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the PA/NP does not function autonomously. The supervising physician shall be responsible for all medical services provided by a PA/NP under his or her supervision.

IV. LIMITATIONS

1. All services performed by the Physician Assistant/Nurse Practitioner shall be subject to the review and evaluation of the appropriate clinical service.

2. Physician Assistants/Nurse Practitioners shall not be members of the Medical staff nor shall they be eligible to vote on medical staff matters or hold office. They will be members of the Affiliate Staff.

V. CONDITIONS GOVERNING THE PRACTICE OF PHYSICIAN ASSISTANTS/NURSE PRACTITIONERS IN THE RURAL HEALTH DEPARTMENT

1. Physician Assistants/Nurse Practitioners will be eligible to practice in the clinics of the Rural Health Department under the supervision of the supervising Family Practice Physician consistent with the following rules and policies. Conditions for Physician Assistant/Nurse Practitioner practice in the Rural Health Department will adhere to the guidelines set forth in Article XII in the Tulare District HealthCare System Medical Staff Bylaws.

2. **Rules:**

   A. Physician Assistants/Nurse Practitioners will document their experience, background, training, judgment and ability in order to demonstrate a professional level of quality patient care.

   B. Physician Assistants/Nurse Practitioners will adhere to the lawful ethics of the Physician Assistant/Nurse Practitioner profession, will work cooperatively in the clinic setting with ancillary departments and will properly delegate staff responsibilities.

   C. Physician Assistants/Nurse Practitioners will work in the Rural Health Department in the clinics including the Mobile Health Clinic.

   D. The supervising physician will always be available by telecommunications when not on site at the clinic/s during the time a Physician Assistant/Nurse Practitioner is participating in patient care.

3. **Policies:**

   A. Specific treatment recommendations/protocols will be considered as Rural Health Department procedures and which will be approved by the Family Practice, Pediatrics and Outpatient Care Service Committee.

   B. PA & NP shall directly call or contact the patient's Primary Care Physician at the clinic in the event of necessary consultation. PA & NP may contact the supervising physician prior to contact.

C. Physician Assistants/Nurse Practitioner is the agent of the supervising physician who is responsible for their activities.

4. **PROTOCOL #1- Scope of Practice**

A. Privileges (scope of practice) of a Physician Assistant/Nurse Practitioner are defined below. Whenever a Physician Assistant/Nurse Practitioner renders patient care within this facility, a supervising physician must be available by telephone or in person while services are being rendered, as required by department regulations and hospital policy. Protocols whereby Physician Assistants/Nurse Practitioners practice will be reviewed periodically by the committee on Interdisciplinary practice and recommended to the appropriate service, the Medical Executive Committee and approved by the Board of Directors.

1. **Scope of care and procedures allowed:**

a. Care and treatment of established patients at the clinic/s of the hospital may include:

i. Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home..

ii. Recording and completion of an appropriate history and physical with adequate progress notes. Initiate, review and revise treatment and therapy plans.

iii. Diagnose and treat conditions listed on page 7-14 within the context of primary care, the scope of their license, the approved protocols and any specifications the supervising physician has delineated.

iv. Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

v. Perform procedures encountered in primary care of the patient such as; administering vaccines, suturing, care of wounds, debridement of superficial wounds/burns, removal of foreign

bodies from the skin and body orifices, removal of sutures, local infiltration of anesthetic, compressive wrap, I&D of superficial abscesses and cryo therapy to appropriate skin lesions.

vi. Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging and understanding of and long-term management of their diseases.

vii. Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community.

viii. Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive of Section 3502.1 of the Code.

ix. Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy and nursing services.

b. Medications:

i. The PA/NP may transmit an order for medication to treat a patient. The medication must by based on the approved standardized protocols/references or be a patient-specific order received from the supervising physician.

ii. The state license number, furnishing number and DEA numbers must be on the transmittal for the PA/NP (if applicable) and the supervising physician.

2. **Authorized Diagnosis and Management**

a. The PA/NP's will be authorized and approved to diagnose and treat common primary care problems, in consultation with the supervising physician, according to the accepted criteria and management.

3. **Procedures**

a. The following procedures may be performed by the PA/NP in accordance with the practice of the supervising physician. In certain cases proctorship of the PA/NP by a supervising physician may be required to document the PA/NP's competency.

i. Foreign body removal
ii. I&D of abscesses
iii. Suture simple and without tendon, muscle or nerve involvement including local infiltration and digital block with anesthesia
iv. Toe and finger nail excisions
v. Simple joint reduction
vi. Anterior nasal packing
vii. BCLS/CPR

4. **Consultation is required for conditions including but not limited to:**

a. All emergency situations

b. Patients requiring hospital admission.

c. Patients requiring outside physician consult.

d. All conditions beyond the PA/NP's scope of training or experience

e. Any time the PA/NP encounters suspicious findings they can not explain (unknown etiology)

f. Any time a patient fails treatment

g. Anything the PA/NP may feel uncomfortable with.

h. All patients presenting to the rural health clinic/s with the following signs/symptoms must be discussed with or evaluated by the supervising physician or other physician at the clinic (if the supervising physician is not present):

i. altered level of consciousness
ii. acute onset of dysrthymia
iii. acute onset of chest pain
iv. fever of unknown origin

v. toxic patients
vi. acute abdominal pain consistent with potential surgical etiology

i. The supervising physician will be consulted whenever the condition/diagnosis being treated in the approved protocols states the supervising physician will be consulted.

j. All EKG's will be reviewed by the supervising physician or their designee for final interpretation.

k. All specialized diagnostic testing will be presented to the supervising before and after completion

VI. References:

1. Books approved to be used as reference guides (but not limited to):

A. Current Medical Diagnosis and Treatment by Tierney, McPhee & Papadakis Appleton & Lange Publisher, current edition

B. Clinical Guidelines in Family Practice, Uphold & Graham Barrymore Books Inc., current edition

C. Griffith's 5 Minute Diagnosis, Dambro, Mark, Williams & Wilkins Publishing, current edition

D. Current Pediatric Diagnosis and Treatment, Hathaway, W.F., Lange Series, current edition

E. Color Atlas and Synopsis of Clinical Dermatology, Fitzpatrick, current edition

RURAL HEALTH DEPARTMENT
PHYSICIAN ASSISTANT/NURSE PRACTITIONER PRIVILEGES AND PROTOCOL

The PA/NP that are employed by the clinic may treat those diagnosis related to primary care of the family. The following diagnoses are examples (not an exclusive list) of primary care diagnosis that the PA/NP may treat or refer to the local emergency department (changed 10/17/08).

The PA/NP may not treat anything they are not competent to treat. They may not treat anything the supervising physician requests they do not treat. They may not treat anything that is beyond the scope of primary care of the family. For example, HIV, end stage renal disease, cancer, or any other diagnosis beyond the scope of primary care or that of the PA/NP.

(REQUESTED)

HEALTH MAINTENANCE

- **Child Health Supervision**
- **Infant Nutrition**
- **Child, Adolescent, and Adult Nutrition**
- **Periodic Health Evaluation for Adults**
- **Dental health Maintenance**

GENERAL

- **Chronic Fatigue**
- **Fever and Fever without Source**
- **Lymphadenopathy**
- **Pain**
- **Weight Loss (involuntary)**

BEHAVIORAL PROBLEMS

- **Alcohol Problems**
- **Attention Deficit Hyperactivity Disorder: THESE PATIENTS WILL BE REFERRED TO A PEDIATRICIAN**
- **Eating disorders**
- **Encopresis**
- **Obesity**
- **Primary Nocturnal Enuresis**
- **Tobacco Use and Smoking Cessation**
- **Undernutrition and Failure to Thrive**

MENTAL HEALTH

- Anxiety Disorders
- Depression
- Domestic Violence: Child Abuse and Neglect
- Domestic Violence: Elder and Disabled Adult Abuse and Neglect
- Domestic Violence: Intimate Partner Abuse
- Grief
- Insomnia

METABOLIC AND ENDOCRINE PROBLEMS

- Diabetes Mellitus
- Dyslipidemia
- Hyperthyroidism
- Hypothyroidism
- Thyroid Nodule
- Gynecomastia
- Precocious Puberty
- Delayed Puberty

INFECTIOUS DISEASE

- Cat Scratch Disease
- Fifth disease (Erythema Infectiousum)
- Influenza
- Kawasaki Disease
- Lyme Disease
- Mononucleosis, Infectious
- Rocky Mountain Spotted Fever
- Roseola (Exanthem Subitum)
- Rubella (Measles)
- Varicella (Chicken Pox)

SKIN PROBLEMS IN CHILDREN AND ADULTS

- Care of Dry and Oily Skin
- Benign Skin Lesions of Infants and Children
- Benign Skin Lesions of Adults
- Cancers of the Skin
- Skin Care, Insect Bite Protection and Sun Exposure Protection
- Acne-Related Disorders
  - Rosacea
  - Acne
- Dermatitis
  - Atopic Dermatitis
  - Contact Dermatitis
  - Keratosis Pilaris

- Pompholyx
- Seborrheic Dermatitis

Bacterial Infections
- Impetigo and Ecthyma
- Cellulitis
- Folliculitis, Furuncles, and Carbuncles

Fungal and Yeast Infections
- Candidiasis
- Dermatophyte Infections
- Tinea Versicolor

Infestation and Bites
- Scabies
- Pediculosis (lice Infestation)
- Cutaneousn Larva Migrans (creeping Eruption)

Papulosquamous Disorders
- Psoriasis
- Pityriasis Rosea
- Lichen Planus

Disorders of Pigmentation
- Pityriasis Alba
- Café au Lait Spot

Viral Infections
- Herpes Simplex
- Herpes Zoster
- Molluscum Contagiosum
- Warts

PROBLEM OF THE EYE
- Amblyopia
- Blepharitis
- Cataract
- Chalazion
- Congenital Nasolacrimal Duct Obstruction
- Conjuctivitis
- Glaucoma
- Hordeolum (stye)
- Strabismus
- Visual Impairment in Children and Adults

PROBLEMS OF THE EARS, NOSE, SINUSES, THROAT, MOUTH AND NECK

Problems of the Ears
- Foreign Body in Ear
- Hearing Loss
- Impacted Cerumen
- Otitis Externa
- Otitis Media, Acute

- Otitis Media with Effusion
- Care of Patient with Tympanostomy Tubes

Problems of the Nose and Sinuses
- Allergic and Nonallergic Rhinitis
- Epistaxis
- Foreign Body in Nose
- Rhinosinusitis

Problems of the Pharynx
- Pharyngitis

Problems of the Month
- Aphthous Stomatitis
- Toothache (pulpitis)

Problems of the Neck
- Cervical Adentitis

PROBLEMS OF THE UPPER AIRWAYS, LOWER RESPIRATORY SYSTEM

- Asthma
- Bronchiolitis
- Bronchitis
- Chronic Obstructive Pulmonary Disease
- Common Cold
- Cough, Persistent
- Croup
- Epiglottitis (Supraglottitis): (DIRECTED TO THE NEAREST EMERGENCY DEPARTMENT)
- Hemoptysis
- Pneumonia in Adults, Community-Acquired
- Tuberculosis

CARDIOVASCULAR PROBLEMS

Diseases of the Heart
- Atrial Fibrillation
- Chest Pain: (DIRECTED TO THE NEAREST EMERGENCY DEPARTMENT)
- Chronic Heart Failure
- Hypertension in Children
- Hypertension in Adults
- Innocent Heart Murmur in children
- Ischemic Heart Disease: Coronary Artery Disease, Stable Angina Pectoris, and the Acute Coronary Syndromes: Acute episodes will be referred to the nearest emergency department. All treatment at the clinic will be in the post acute/follow up stage.
- Presyncope/Syncope

Peripheral Vascular Disorders
- Deep Venous Thrombosis

- Leg Ulcers
- Peripheral Arterial Disease: Chronic Lower Extremity Arterial Occlusive Disease
- Varicose Veins

GASTROINTESTINAL PROBLEMS

- Acute Abdominal Pain in Adults
- Acute and Recurrent Abdominal Pain in Children
- Acute Diarrhea
- Nausea and Vomiting
- Constipation in Adults
- Constipation in Infants and Children
- Irritable Bowel Syndrome
- Peptic Ulcer Disease
- Gastroesophageal Reflux Disease (GERD)
- Gastroesophageal Reflux in Infants
- Colic
- Hyperbilirubinemia in the Healthy Term Infant
- Hernias (Abdominal)
- Hemorrhoids
- Dysphagia in Adults
- Cholecystitis
- Abnormal Liver-Enzymes Results
- Viral Hepatitis
- Parasitic Infections of the Intestine
  - Ascariasis (Roundworm Infections)
  - Enterobiasis (Pinworm Infection)

GENITOURINARY PROBLEMS

- Benign Prostatic Hyperplasia
- Chronic Kidney Disease in Adults
- Erectile Dysfunction
- Hematuria
- Interstitial Cystitis
- Urinary Tract Infections
  - Cystitis and Pyelonephritis in Adolescents and Adults
  - Cystitis and Pyelonephritis in Children
  - Prostatitis
- Problems of the Scrotal Contents
  - Epididymitis
  - Testicular Torsion: Directed to the nearest emergency department (changed 10/17/08)
  - Hydrocele
  - Varicocele
  - Undescended Testes (Cryptorchisdism)

GYNECOLOGY

- Abnormal papnicolaou (pap) smear
- Abnormal Uterine Bleeding
- Amenorrhea
- Bartholin's Gland Cysts and Abscesses
- Breast Mass
- Contraception
- Dysmenorrhea
- Premenstrual Syndrome
- Menopause
- Vulvovaginal Candidiasis

SEXUALLY TRANSMITTED DISEASES

- Bacterial Vaginosis
- Trichomoniasis
- Chlamydial Infection
- Gonorrhea
- Mucopurulent Cervicitis
- Nongonococcal Urethritis
- Pelvic Inflammatory Disease
- Syphylis
- Genital Herpes Simplex Virus (HSV) infection
- Human Papillomavirus Infection (Genital Warts)

MUSCULOSKELETAL PROBLEMS

- Ankle Sprain
- Common Orthopedic Deformities in childhood
- Elbow Pain
- Fibromyalgia
- Gout
- Joint Pain
- Knee Injury, Acute
- Low Back Problems, Acute
- Lower Extremity Pain, Overuse Injuries
- Osteoarthiritis
- Osteoporosis
- Plantar Fasciitis
- Rheumatoid Arthritis
- Scoliosis
- Shoulder Pain
- Wrist Pain

NEUROLOGIC PROBLEMS

- Acute Facial Paresis (Bells Palsy)
- Alzheimer's Disease
- Dizziness

Febrile Seizures
Headache
Parkinson's Disease
Seizures and Epilepsy
Stroke and Transient Ischemic Attack: ACUTE EPISODES WILL BE REFERRED TO THE NEAREST EMERGENCY DEPARTMENT. ALL TREATMENT AT THE CLINIC WILL BE IN THE POST ACUTE/FOLLOW UP STAGE.
Tremor

HEMATOLOGIC PROBLEMS

Anemia of Chronic Disease
Iron Deficiency Anemia
Megaloblastic Anemia

MINOR EMERGENCIES

Avulsed Tooth
Bite Wounds
Burns, Minor
Corneal Abrasions
Head Trauma, Minimal & Mild
Insect Stings and Brown Recluse Spider Bite
Eyelid foreign Body
Subconjunctival Hemorrhage
Wounds

Descriptive Name: Physician Assistant/Nurse Practitioner Protocols/Guidelines for the Rural Health Department Affiliate Staff

Descriptive Type: ~~New~~Revised policy

Document Number: 20-1003

Attachments: None

Author: ~~Carol Thiel~~Angie Graziano

Typist: ~~Julie Gresham~~Andrea Carrasco

Creation Date: 8/3/08

Revised Date: 4/24/18

Prev. Dist. Date: None

Committee Review and Approval:	Approval Date:	Comments:
OB/Pediatric Committee	N/A~~11/12/08~~	Date change only
Family Practice Committee	N/A~~11/12/08~~	Date change only
Interdisciplinary Committee	N/A~~11/12/08~~	Date change only
MEC	N/A~~11/12/08~~	Date change only
Board of Directors	~~11/19/08~~	

Effective Date: ~~11/20/08~~

Forward To: Policy Binders (PBX and Administration) and post to Intranet

Disposition: Copy and Distribution - Administration

Comments: Policy reviewed with Clinic Medical Director (Dr. Pradeep Kamboj) prior to committee review

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Human Immunodeficiency Virus (HIV) Testing

PURPOSE: To facilitate a uniform process of testing for HIV Antibody while maintaining patient confidentiality.

EQUIPMENT HIV Antibody Testing and Authorization for Disclosure

PROCEDURE:

A. When an order is written for HIV Antibody test, effective January 1, 2008, a written consent is no longer necessary, however prior to ordering the HIV test, the "medical care provider" must according to(California Department of Public Health Assembly Bill 682, 2008):

1. Inform the patient that the test is planned

2. Provide information about the test to the patient

3. Inform the patient that there are numerous treatment options available for a person who tests positive for HIV

4. Advise the patient that routine testing is recommended for patients who test negative for HIV

5. Advise the patient that he or she has the right to decline the test

6. If the patient declines the HIV test, note that fact in the patient's medical file

B. Laboratory testing procedure for HIV

1. The hospital personnel will draw the blood and process the request.

2. Lab personnel will forward one (1) copy of the results to the person authorized to receive the results, or another copy to the patient's chart, if appropriate.

Effective Date:	(20)	Infection Control Human
Approved:		Immunodeficiency Virus (HIV) Testing
Medical Executive Comm.:		20-8002.1

Board of Directors:

3. Testing may in some cases be performed without the patient's consent where there has been a significant exposure of health care personnel to potentially infectious materials.

4. TRMC employees with a work related exposure, see policy #20-8007 Blood and Body Fluid Exposure Control and Guidelines Section II B **Multidisciplinary Reporting Responsibilities** authorizing results to be sent to the Infection Preventionist.

5. See attached "HIV" Testing in Health Care Settings" (English/Spanish) from the California Department of Public Health. Additional forms can be obtained in other languages from:

   http://www.cdph.ca.gov./pubsforms/forms/CtrldForms/cdph8700.pdf

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

HIV Testing in Health Care Settings

During your health care visit today your medical care provider may want to perform an HIV test. The following are answers to questions that people often have about HIV testing:

What is HIV?
Human immunodeficiency virus (HIV) causes a disease that weakens the immune system, making it hard for the body to fight infections.

How is HIV transmitted?
HIV is spread by the exchange of certain bodily fluids, primarily by having unprotected sex or sharing needles with an HIV-infected person.

What is an HIV test?
An HIV test determines if your body is producing antibodies to HIV. If you have HIV antibodies this means that you have been infected with HIV. There are both conventional and rapid HIV tests which use blood, plasma, or saliva to test for the antibodies.

What if I test HIV positive?
If you are HIV positive, you will want to discuss treatment options with your medical care provider. Many HIV treatment options exist for people who are HIV positive.

What if I test HIV negative?
Protect yourself as described below. If you have unprotected sex or share needles for any reason, you should have an HIV test every year.

You can protect yourself and others from HIV by:

- Using a latex/polyurethane condom (male or female) when you have sex. (Use only water-based lubricants. Oil-based lubricants will make condoms less effective.)
- Not sharing needles for injecting drugs, steroids, vitamins, tattooing, or piercing.

Other resources for help:
Call the California HIV/AIDS Hotline at (800) 367-2437 (AIDS) for HIV referral and consultation resources in your area or visit the Office of AIDS Web site at: http://www.cdph.ca.gov/programs/AIDS/Pages/OAHIVTestHCS.aspx.

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

La Prueba del VIH en los Centros de Salud

Durante su cita hoy, es posible que su médico quiera realizar una prueba del VIH. Lo siguiente es una lista de preguntas y respuestas para darle más información sobre la prueba.

¿Qué es el VIH?
El virus de la inmunodeficiencia humana (VIH) causa una enfermedad que debilita el sistema inmunológico. El VIH hace que el organismo no pueda combatir las enfermedades eficazmente.

¿Cómo se transmite el VIH?
El VIH se transmite a través de ciertos fluidos corporales, principalmente a través del sexo sin protección o por compartir las agujas/jeringas con una persona infectada del VIH.

¿Qué es la prueba del VIH?
La prueba del VIH determina si su cuerpo produce anticuerpos contra el VIH. Si usted produce anticuerpos del VIH, esto significa que usted ha sido infectado. Existen pruebas convencionales y rápidas que utilizan la sangre, el plasma, o la saliva para detectar los anticuerpos.

¿Qué sucede si el resultado de mi prueba es VIH-positivo?
Si su prueba da un resultado VIH-positivo, su médico le explicará las opciones de tratamiento. Existen muchas opciones para personas que tienen el VIH.

¿Y si el resultado es VIH-negativo?
Hay varias maneras de protegerse y mantener su estado VIH-negativo, como se describen a continuación. Si por cualquier motivo tiene relaciones sin usar condones, o si comparte agujas o jeringas, es recomendable hacerse la prueba del VIH cada año.

Puede protegerse y a los demás por:
• Utilizar un condón de látex/poliuretano (masculino o femenino) cada vez que tenga relaciones sexuales. (Sólo debe usar lubricantes a base de agua. Los lubricantes derivados del aceite dañan a los condones y los hacen menos eficaces).

• No compartir las agujas o jeringas para inyectar las drogas, los esteroides, las vitaminas, los tatuajes, o para perforar.

Otros recursos:
Llame la Línea Directa del VIH/SIDA de California al (800) 367-2437 para recursos de referencia y consulta en su área o visite la página web de la Oficina de SIDA en: http://www.cdph.ca.gov/programs/AIDS/Pages/OAHIVTestHCS.aspx.

Descriptive Name: Human Immunodeficiency Virus (HIV) Testing

Descriptive Type: Revised

Document Number: 20-8002.1

Attachments: 2

Author: Joshua Warren

Typist: Maritza Sevillano

Creation Date: 08/27/09

Revision Date: 4/17/18

Prev. Dist. Date: 05/24/12

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	N/A	Date change only
MEC	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Environmental Control Cultures and ~~-~~Monitoring~~:~~

Environmental culturing shall be performed for the purpose of ongoing monitoring of the sterilization process, and for epidemiological purposes. Routine environmental sampling is not recommended per CDC and ~~AHA~~ APIC recommendations.

A. Sterilization monitoring is performed **daily and with all implants** by Central Supply staff, using the live spore method.
   1. Gas or hot air sterilizer (Bacillus stearothermophilis – 56 degrees C).
   2. Results are logged in a book and kept in Central Supply.

B. Environmental surfaces and equipment may be tested at random, as requested by Environmental Services, the Infection Control Nurse or Department Manager.

C. Microbiological surveillance testing of patients and/or personnel will be performed only for epidemiologic purposes (outbreak investigation). In the event of an "outbreak" or epidemic situation, a sufficient number of environmental cultures may be performed at the request of and under the supervision of the Infection Control Nurse, and/or the Infection Control Committee. The results will be reported to Administration, Chief of Clinical Services and Infection Control Committee.

The Infection Control Nurse/Lab Scientist shall have the following responsibilities:

1. Determine those areas to be tested.

2. Obtain culturing material from the Laboratory

3. Coordinate and ensure all determined sample specimens are taken in the appropriate manner and on a timely basis.

4. Ensure all sample specimens are returned to the laboratory on a timely basis.

5. Maintain records of the environmental cultures.

Effective Date:

APPROVED:

Medical Executive Comm.:

Board of Directors:

(20) Clinical Guidelines
Infection Control:
Environmental Control Cultures
20-8014

6. Work with department managers and Laboratory Staff to rectify high-count cultures and pathogen findings.

7. Report the steps taken and results of remediation in a timely manner to the Laboratory and Infection Control Committee.

The Laboratory shall be responsible for the following:

1. Perform all specimen testing on a timely basis.

2. Notify the Infection Preventionist immediately of all high-count results and when any pathogens are identified.

3. Make recommendations to rectify either of the above.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Environmental Control Cultures and Monitoring

Descriptive Type: Revised

Document Number: 20-8014

Attachments: None

Author: Joetta Denney

Typist: Melissa Arend

Creation Date: 08/24/06

Revision Date: 08/23/17

Prev. Dist. Date: 10/01/15

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: Contracted Laundry Service, Infection Prevention Committee, Clinical Services and Environmental Services

FROM: Administration

SUBJECT: Visit to Contract Laundry Service

Tulare Regional Medical Center utilizes commercial contracted services for supply of Hospital laundry.

In an effort to insure such service meets and/or exceeds sanitary and anti-infection standards, routine inspection of the commercial laundry site shall occur.

I. The laundry service site will be inspected annually by the Director of Environmental Services and the Infection Preventionist to insure that the following standards are maintained:

   A. The laundry is well lighted, well ventilated, and has adequate floor space to meet the needs of the hospital and for the protection of employees.

   B. The laundry shall be maintained in a sanitary manner and kept in good repair.

   C. There shall be no open storage areas of soiled linens in the laundry proper.

   D. All linens are washed with an effective soap or detergent and thoroughly rinsed to remove soap or detergent and soil per product or technology manufacturer. All linens are washed at a water temperature of at least 71 C (160 F) for at least twenty-four (24) minutes. Record the temperature of the wash water cycle at least daily.

   E. A separate room is maintained to store clean linen, and a separate room is maintained to store soiled linen. Linen storage rooms are large enough and are used for no other purpose. Storage areas do not include attic spaces, corridors, or plenums (air distribution chambers) of air conditioning or ventilation systems.

Effective Date:

APPROVED:

Medical Executive Comm.:

Board of Directors:

(20) Clinical Guidelines
Infection Control:
Visit to Contract Laundry Services
20-8015

F. Hand-washing and toilet facilities for laundry personnel are provided conveniently close to the laundry work site.

G. Soiled and clean linens are properly labeled and provided with covers made of washable material, which are laundered, or suitably cleaned daily.

Soiled Linen:

A. All soiled linen is assumed to be contaminated with potentially infectious organisms, and are handled following Standard Precautions:

1. Personnel handling soiled linens use appropriate barriers to protect themselves against exposures to potentially infectious organisms including industrial strength gloves, and moisture resisting gowns and masks. Replace when soiled.

2. Linens are handled with caution to avoid injury from needles or other sharp objects, which may have been left in the linens.

3. All cuts, needlestick injuries or other significant exposures to blood or other bodily fluids are reported immediately.

4. Contracted services frequently in-services employees on blood and body fluid precautions and infection control practices.

B. Soiled linens are sorted in a separate enclosed room by persons instructed in safe handling and protection from contamination.

C. Persons handling soiled linens are not assigned to duties involving handling of clean linens.

D. Soiled linens are completely confined and contained for storage and handling. Containers used for transporting soiled linens are not used for transporting clean linens and are cleaned before reuse. Linen carts are covered during the transportation process.

E, Ventilation from the soiled linen area does not flow into the clean linen area.

Clean Linen:

A. Clean linen are sorted, handled and transported in such a manner as to prevent cross-contamination.

1. Persons processing clean linen are dressed in clean garments at all times, and are not to handle soiled linens.

2. Clean linens that touch the floors are handled appropriately according to Laundry Service Policies and state regulations.

3. Clean linen carts are used only for the purpose of transportation and/or storage of clean linen.

4. Clean linens sorted in the laundry area are stored in a room separate from the sorting room, laundry room, or soiled linen room.

5. Clean linens from the commercial laundry service are delivered to the hospital completely wrapped, and are delivered to a designated clean area.

II. Contracted Services develops a contingency plan in the event that linen reprocessing and transport services are disrupted.

III. A report of the on-site survey shall be forwarded to the Medical Staff, Infection Control Committee and contracted commercial laundry site managers by the Infection Preventionist, and maintained in the Committee minutes.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

ATTACHMENT A

TULARE REGIONAL MEDICAL CENTER
Contracted Laundry Tour Survey Checklist
Date, Month, Day, Year

Item	Met	Not Met	Comment
Laundry area is well-lighted, well-ventilated, and has adequate floor space to meet the needs of the hospital.			
Laundry is maintained in a sanitary manner and kept in good repair.			
No open storage areas of soiled linen in the laundry area.			
Linens are washed with effective soap/detergent and thoroughly rinsed.			
Linen washed at water temp of 160° F for at least 24 minutes. Temperatures recorded daily.			
Separate rooms for storage of clean linen vs. soiled linen. Storage areas do no include attic spaces, corridors, or plenums.			
Handwashing and toilet facilities for employees are provided conveniently close to the work site.			
Soiled linen and clean linen properly labeled and covered appropriately.			
Standard Precautions and PPE's are used as needed.			
Employees that handle soiled linen do not handle			

Item	Met	Not Met	Comment
clean linen.			
Containers for transport of soiled linen are not used for clean linen and carts are cleaned before use. Carts are cleaned on a regular basis.			
Linen Carts are covered during the transportation process			
Employees are in-serviced on blood and body fluid precautions and infection control practices.			
Linens are handled with caution to avoid injury from needles or other sharp objects.			
Clean linen that touches floor is handled appropriately according to state regulations and laundry service policy.			
Clean linens from the commercial laundry service are delivered to the hospital wrapped and delivered to the designated clean area.			
Contingency plan in the event that linen reprocessing and transport services are disrupted.			
Quality Control Measures			

INFECTION PREVENTIONIST's or REPRESENTATIVE's

Signature: _____/ Date: _____

Descriptive Name: Visit Contracted Laundry Services

Descriptive Type: Revised Policy

Document Number: 20-8015

Attachments: Attachment A

Author: Joetta Denney

Typist: Melissa Arend

Creation Date: 02/25/10

Revision Date: 08/23/17

Previous Dist. Date: 10/29/15

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders – (PBX and Administration) and Post to Intranet Site

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Cautious Handling of Materials and Equipment Prior to Decontamination and Decontamination Process

PURPOSE: To ensure safe handling of materials and equipment prior to and during decontamination.

EQUIPMENT: All staff must wear personal protective equipment appropriate for the handling of materials and equipment being washed or decontaminated.

- ❖ For washing of equipment and materials gloves and any other appropriate protective gear are required.

- ❖ For decontamination central processing staff use the following:

1. Wear protective attire
2. Plastic apron
3. Shoe covers
4. Heavy Gloves
5. Hair cover
6. Eye Protection
7. Scrub uniform

DEPARTMENTAL PROCESS:

1. All departments shall decontaminate ~~(soak)~~ their own instruments with water and detergent or manufacturer's suggested cleaning agent, in the department prior to Central Processing pick ups.

2. After departmental cleaning, Central Processing staff will pick up used supplies and equipment, (supplies and equipment should be covered, enclosed in plastic bags, or on covered carts).

Effective Date:

APPROVED:

Medical Executive Comm.:

Board Of Directors:

(12) Clinical Guidelines
Infection Control:
Cautious Handling of Materials and Equipment Prior to Decontamination and Decontamination Process
#20-8017

Pickups are scheduled twice a day and brought back to Central Processing for Decontamination.

- ❖ Item must be thoroughly cleaned prior to disinfection.
- ❖ Items should be dry to prevent dilution of the disinfectant.

3. When personnel leave the decontamination area, the apron, shoe cover, gloves, hair cover, must be removed; clean protective attire should be donned upon returning to the area.

ENVIRONMENTAL SERVICES RESPONSIBILITIES:

1. Environmental Services will mop Central Processing area daily.

2. All work counters, sinks, and incoming carts will be cleaned with a low-level disinfectant at least once every shift (carts are cleaned every time it is incoming).

3. When personnel leave the decontamination area, the apron, shoe cover, gloves, hair cover, must be removed; clean protective attire should be donned upon returning to the area.

ASEPTIC TECHNIQUE:

1. Sterile goods dropped on the floor will be reprocessed before use.

2. In the operating room: sterile supplies will be stored in the sterile supply room and cupboards in the operating rooms and sub-sterile areas. Unsterile supplies and equipment will be stored in the unsterile supply room.

3. All other departments will have a designated clean area to store sterile wrapped supplies.

   Central processing department performs terminal decon and processing for future use.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines and is effective immediately.

Descriptive Name: Cautious Handling of Materials and Equipment Prior to Decontamination and Decontamination Process

Descriptive Type: Revised

Document Number: 20-8017

Attachments: None

Author: Joetta Denney

Typist: Melissa Arend

Creation Date: 04/23/06

Revision Date: 08/25/17

Prev. Dist. Date: 10/01/15

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

DELETE

TO: All Departments

FROM: Administration

SUBJECT: Definitions of Healthcare Associated Infections (HAI)

Purpose:

I. The Infection Prevention and Control Committee recognizes the overall goal of the Infection Prevention and Control Program is to maintain and contain infections within the hospital confines. In this effort, the Committee follows the current CDC Definitions of Healthcare Associated Infections established to recognize and identify infections that are acquired while the patient is in the hospital. The Committee also deems that prevention of an infection is one of their highest priorities ultimately leading to continued and consistent positive patient outcomes.

To meet this purpose the committee will:

A. Utilize CDC's tool for providing definitions for Healthcare Associated Infections identified by surveillance and reported to the Infection Prevention and Control Committee, the National Healthcare Safety Network (NHSN), and Centers for Medicare and Medicaid Services for monitoring and prevention.
Found at: http://www.cdc.gov/nhsn/pdfs/pscmanual/17pscnosinfdef_current.pdf

B. Follow the recommendations from The Joint Commission Sentinel Event Alert Issue #28 (http://www.jointcommission.org/assets/1/18/SEA_28.pdf) and/or other accrediting agency recommendations and the National Patient Safety Goals regarding "Infection Control related sentinel events". The Committee will refer as sentinel events all questionable/identified cases of death and major permanent loss of function attributed to a Healthcare Associated Infection to the Risk Manager for further analysis. The committee will follow the attached criteria algorithm to determine this association (See attachment A). The sentinel event investigation will be performed in accordance with Policy #10-1035.2

Effective Date:

Approved:

Medical Executive Comm.:

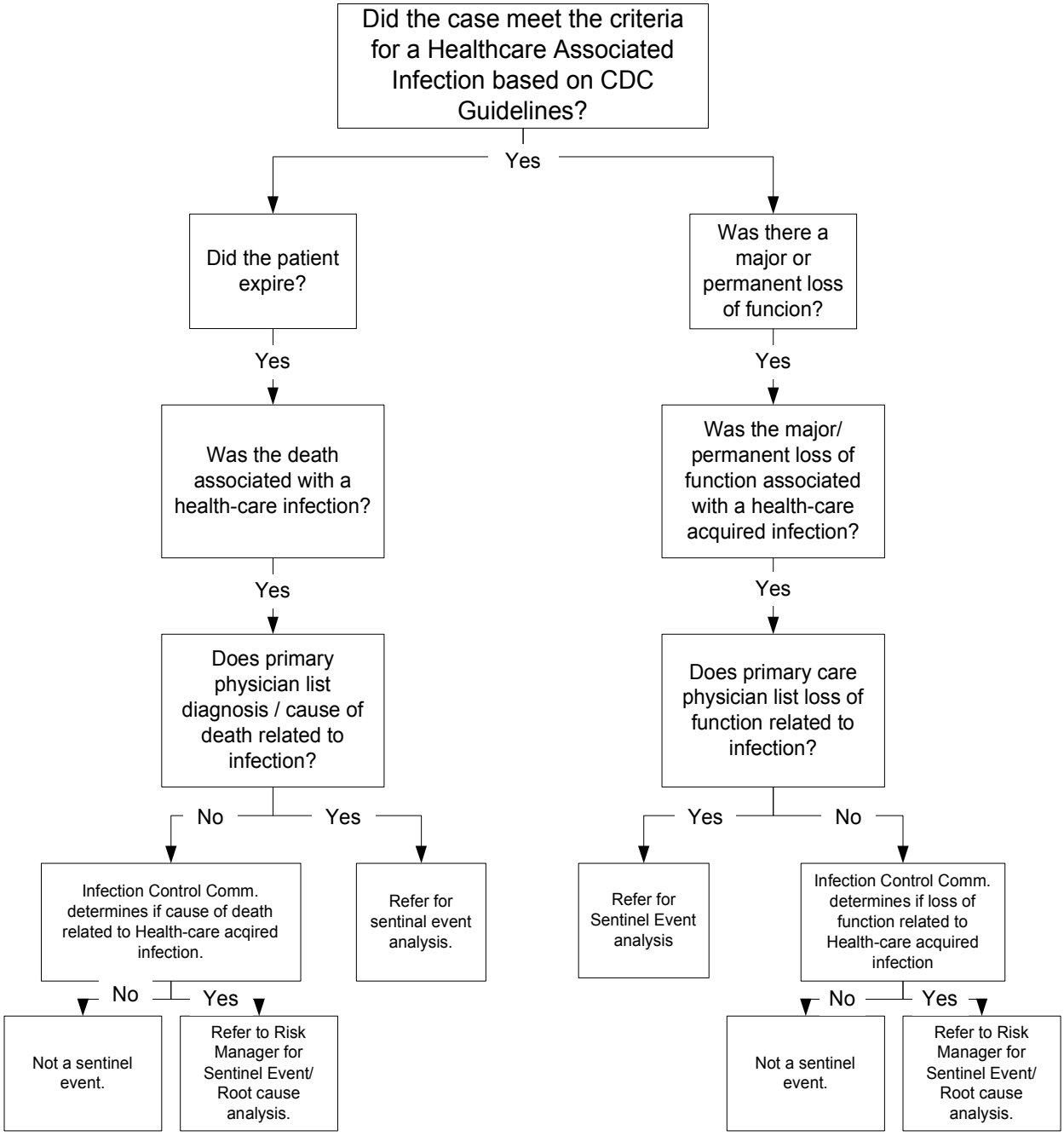
Board of Directors:

(20) Clinical Services Guidelines
Infection Prevention:
Definitions of
Healthcare Associated
Infections (HAI)
20-8020

ATTACHMENT A

The Joint Commission National Patient Safety Goals
Health-Care Acquired Infections Related to Death or Loss of Function

Potential Criteria Algorithm



Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Definitions of Healthcare Associated Infections (HAI)

Descriptive Type: DELETE

Document Number: 20-8020

Attachments: Flowchart

Author: Joetta Denney

Typist: Melissa Arend

Creation Date: 04/27/11

Revision Date: 08/29/17

Prev. Dist. Date: 10/01/15

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee		
MEC		
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: CDC Hand Hygiene Guidelines

PURPOSE:

These recommendations are designed to improve hand-hygiene practices of health care workers and reduce transmission of pathogenic microorganisms to patients and personnel in healthcare settings.

1. Tulare Regional Medical Center will use the CDC recommended guidelines *MMWR 2002; 51 - NO. RR-16 Guideline for Hand Hygiene in Healthcare Settings as a reference.*

2. <u>All personnel will use the recommended hand hygiene techniques under the following circumstances:</u>

3. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or bodily fluids, **wash** hands with either an antimicrobial soap and water or a non-antimicrobial soap and water and:

   A. Before eating and after using the restroom

   B. After exposure to Bacillus anthracis is known or suspected – See MMWR 2002 reference.

   C. After exposure to Clostridium difficile related infections during outbreaks or evidence of ongoing transmission-See APIC Guide to C. difficile 2008 reference.

   D. After exposure to Norovirus (Norwalk-like Virus) related infections during outbreaks or evidence of ongoing transmission.

   E. Alternatively, wash hands with antimicrobial soap and water in all clinical situations.

4. When hands are NOT visibly soiled, use an **alcohol-based hand rub** for routinely decontaminating hands in all other clinical situations:

Effective Date: 10/01/15 (20) Clinical Guidelines
Infection Control:
APPROVED: CDC Hand Hygiene Guidelines
20-8025
Medical Executive Comm.: 09/09/15

Board of Directors: 09/30/15

A. **Before** having direct contact with patients.

B. Before donning sterile gloves and inserting any invasive device.

C. After contact with patient's intact skin, i.e., taking a patient's blood pressure, pulse, lifting/moving the patient.

D. After contact with bodily fluids, excretions, mucous membranes, non-intact skin and wound dressings, if hands are not visibly soiled.

E. After moving from a contaminated body site and then moving to a clean body site on the same patient

F. After contact with medical equipment/supplies in patient areas.

G. Always after removing gloves.

H. Leaving an isolation area.

I. After smoking

J. After blowing or wiping the nose

5. It is the policy of TRMC to prohibit Alcohol-based hand rub dispensers from being installed in egress corridors. Dispensers containing Alcohol-based hand rub solutions will be installed inside patient care rooms and nursing stations, as long as placement in the nursing station is in a contained area and not clearly in an egress path. Dispensers containing these types of solutions will not be installed (or stored) near a heat or ignition source, electrical outlet, or light switch.

DEFINITIONS:

1. Alcohol-Based Hand Rub: An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands.

2. Antimicrobial Soap: Soap containing an antiseptic agent.

3. Antiseptic Agent: Antimicrobial substances that are applied to the skin to reduce the number of microbial flora. Examples include alcohols, chlorhexidine, PCMX, quaternary ammonium compounds and triclosan.

4. Plain Soap: Detergents that do not contain antimicrobial agents.

5. Waterless Antiseptic Agent: An antiseptic agent that does not require water. After applying such an agent, the hands are rubbed together until the agent has dried.

PROCEDURE FOR HAND HYGIENE TECHNIQUE:

1. Using an alcohol-based hand rub for **decontamination**:

   A. Apply product to palm of one hand, rub hands together, covering all areas of the hands and fingers, until hands are dry.
   B. Follow the manufacturer's recommended guidelines for the amount of alcohol-based hand rub.

2. Using **antimicrobial soap and water** or non-antimicrobial soap and water:

   A. Keep clothing away from sink and splashes.

   B. Wear minimal jewelry.

   C. Employees having **direct contact with patients** in **all** patient care areas including respiratory therapy, physical therapy, laboratory, home care, rural health clinics, medical imaging, central processing/sterile processing, pharmacy, dialysis and sleep lab must keep nails short < ¼ inch in length, and may not wear artificial nails (i.e. nail products that must be mixed and then dried – "grinded", extenders), or nail jewelry. Employees may wear a thin layer of nail polish (including gel and shellac polish) that can be painted on with a brush and do not require mixing of products. Refer to table below for prohibited and allowed fingernail products. Also, refer to Policy #15-2028 Code of Personal Appearance, for any additional restrictions.

Prohibited	Allowed
Extenders	Nail Polish
Long Nails > ¼ inch past finger tip	Gel Polish
Adornments such as jewelry	Shellac Polish
Acrylic, wrap nails or extenders	

   References: CDC. (2002). *Guideline for Hand Hygiene in Health Care Settings*. MMWR. p. 78; WHO. (2006) *Guidelines on Hand Hygiene. p. 76*; The Joint Commission, (2009). *Hand Hygiene-Fingernails*. FAQ.

   D. Turn on water and adjust temperature for your comfort.

   E. Wet hands and apply manufacturer's recommended amount of soap to hands. Lather well (soap reduces surface tension enabling the removal of bacteria).

   F. Clean fingernail area (bacteria may be harbored beneath fingernails).

G. Wash hands thoroughly, using rigorous scrubbing action for at least 15 seconds. Work lather around fingernails, top of hands, etc. (to facilitate eradication of all bacteria).

H. Rinse hands and wrists under running water.

I. Repeat hand-hygiene technique, if necessary (to prevent recontamination of hands).

J. Dry hands with clean paper towel. (Multiple use towels, i.e., rolling towels, are not recommended for healthcare facilities.)

K. Turn off faucets with used paper towel and discard.

L. Avoid using hot water for hand-hygiene. Repeated use of hot water may increase the healthcare worker's risk of dermatitis.

3. Surgical hand antisepsis (OR and OB and Cath Lab):

A. Remove rings, watches and bracelets before beginning the surgical hand scrub.

B. Remove debris under the fingernails using a nail cleaner under running water.

C. Surgical hand antisepsis using either an antimicrobial soap with persistent activity or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures.

D. When performing surgical hand antisepsis using an antimicrobial soap with persistent activity, scrub hands and forearms for the length of time recommended by the manufacturer. Usually 2-6 minutes. Long scrub times (e.g.10 minutes) are not necessary.

E. When using an alcohol-based surgical hand care product with persistent activity, follow the manufacturer's instructions. Before applying the alcohol solution, pre-wash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product as recommended allow hands and forearms to dry thoroughly before donning sterile gloves.

4. Selection of Hand Hygiene Agents:

A. Provide personnel with efficacious hygiene products with low irritancy potential.

B. Input will be solicited from employees using the product regarding feel, fragrance and skin tolerance of any products. Employees will consider that cost of the product will not dictate nor be the primary factor in product selection.

C. Manufacturer information will be solicited regarding known interactions between cleaning products; skin care products, gloves and dispensers.

D. Employees will be provided with hand lotions or creams to limit contact dermatitis and occurrence of irritation, antimicrobial soap, alcohol-based hand cleaner and pocket-sized containers in a convenient location.

E. Employee input will be solicited in the Hand Hygiene Team, Product Evaluation Committee, and Infection Prevention & Control Committee and via evaluations in the clinical areas.

NOTES:

1. Always follow Standard Precautions.

2. Gloves are to be worn when contact with blood, bodily fluids, mucous membranes, dressings, non-intact skin, etc., is anticipated.

3. Change gloves and discard after each patient contact. One pair of gloves – one patient.

4. Change gloves when moving from a contaminated body site to a clean body site on the same patient.

5. TRMC staff does not wash gloves between uses.

6. Education is an institutional priority:

   A. Education regarding hand hygiene will be conducted during General Orientation for new employees and yearly Annual Update.

   B. Additional continuing education regarding hand hygiene will be provided through the development of a “Campaign” to reinforce the hospital policies regarding Hand Hygiene. The “Campaign” methods will be determined by the Infection Prevention Staff annually and will include an organization-wide (including Rural Health Clinics and Home Care) effort.

7. Performance Improvement:

   A. Infection Prevention and Control Program will monitor and record adherence to hand hygiene guidelines. The number of hand hygiene episodes performed (N) versus number of hand hygiene opportunities (D) will be assessed. Improvement opportunities will be determined based on overall results.

B. Infection Prevention and Control Program will provide feedback to Directors and report findings through both the Infection Prevention and Control Committee and the Performance Improvement Committee.

C. Infection Prevention & Control Program/Environmental Services (EVS) will monitor the volume of hand hygiene alcohol-based hand rub/soap used per 1,000 patient days.

D. Adequacy of hand hygiene adherence will be assessed in the event of an outbreak of infection.

8. Hand Hygiene Compliance Monitoring:

Hand hygiene is monitored through informal observations made on the units, departments and clinics throughout the organization. The observations are recorded and logged in a Hand Hygiene Surveillance database that is shared with the Quality Department. Rates of hand hygiene compliance are tracked and trended as a part of performance improvement.

A. 1st Offense of not performing hand hygiene results in a citation and a hand hygiene pamphlet (see *Attachment A and B*) being provided to employee

B. 2nd Offense of not performing hand hygiene results in a second citation and an evaluation of hand hygiene competency with the employee (see *Attachment C*)

C. 3rd Offense of not performing hand hygiene results in a third citation. The employee will be required to re-take the infection prevention and control education module within 1 week of citation. Employee manager/director will be notified. This may result in a deduction in employee evaluation points.

*Citations are monitored cumulatively for a 12 month period. Employees who have 3 offenses within a span of 12 months will receive a memo for “three strikes”. However, if the 3rd offense occurs on the 13 month the employee will receive a 1st citation and a hand hygiene pamphlet as a “clock” restarts anew each 12 month period (see *Attachment A*: (Hand Hygiene Citation))

ATTACHMENT A
(Hand Hygiene Citation)

Reminder

Tulare Regional Medical Center

You missed an opportunity to protect your patients and yourself!

Before Patient Contact:	After Patient Contact:	After Body Fluids:
Wash Rub	Wash Rub	Wash Rub
In-Between Patients:	**After Gloving:**	**Dirty to Clean:**
Wash Rub	Wash Rub	Wash Rub

Hand Hygiene Saves Lives!

TRMC Infection Prevention
Dept. Ext. 3895

Observed by:

Signature

ATTACHMENT B:
(Hand Hygiene Pamphlet)

Terms

Alcohol Based Handrub
Alcohol-containing preparations designed for hand application to reduce the numbers of viable microorganisms on the hands.

Antimicrobial Soap
Soap (i.e. detergent) containing an antiseptic agent.

Decontaminate Hands
To reduce bacterial counts on hands by performing antiseptic handrub or antiseptic handwash.

Hand Hygiene
A general term that applies to handwashing, antiseptic hand wash, antiseptic handrub, or surgical hand antisepsis.

Persistent Activity
Refers to the prolonged or extended antimicrobial activity that prevents or inhibits the growth or survival of microorganisms following application of the product.

Plain soap
Detergents NOT containing antimicrobial agents or contain low concentrations of antimicrobial agents effective solely as preservatives.

Proteinaceous
Any substance composed of proteins (i.e. fecal Matter)

Surgical Hand Antisepsis
Antiseptic handwash or antiseptic handrub performed preoperatively by surgical personnel to eliminate transient and reduce resident flora. Antiseptic detergent preparations often have persistent antimicrobial activity.

Visibly Soiled Hands
Hands showing visible dirt or that are visibly contaminated with proteinaceous material, blood, or other body fluids. (e.g. fecal material

Source Sites:
- Association of Professionals in Infection Control and Epidemiology, Inc. (APIC): www.apic.org
- Center for Disease Control: www.cdc.org

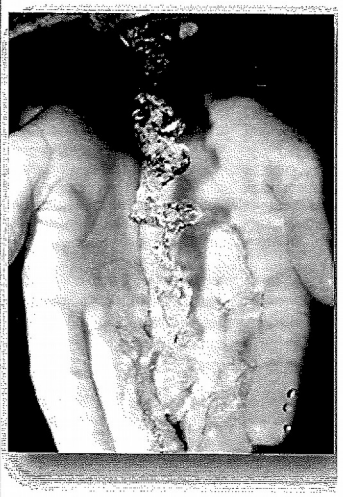
Revised and Approved 0816.11

Important Tips

- When washing hands, repeated use of HOT (vs. warm) water may increase the risk of dermatitis.
- Liquid, bar leaflet or powdered soap is acceptable for handwashing with nonantimicrobial soap and water.
- Handwashing, NOT alcohol-based handrubs, should be used to clean hands contaminated by bacterial spores such as *Clostridium difficile* or *Bacillus anthracis* (Anthrax).
- Choose alcohol handrubs containing 60-95% isopropanol, ethanol or n-propanol per CDC Hand Hygiene Guidelines.
- Choose alcohol handrubs with 1-3% glycerol or other emollients.
- Alcohol-based handrubs, rinses and gels containing emollients cause LESS skin irritation and dryness than soaps OR antimicrobial detergents tested.
- Alcohol-based handrubs, etc., should be stored away from high temperatures, flames, electrical outlets or oxygen receptacles, according to recommendations from the National Fire Protection Agency (NFPA).
- It is NOT necessary, or recommended, to routinely WASH hands after application of alcohol-based handrubs.
- Provide moisturizing skin care products or barrier creams for employee use. Ensure these products will not compromise glove barrier.
- Use of antimicrobial-impregnated wipes is considered equivalent to handwashing, but they are not considered a substitute for alcohol handrubs or antimicrobial soap.

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274
559.688.0821 • www.TulareRegional.org

For more information:
Infection Prevention Department 559.685.3487



Hand Hygiene for Healthcare Professionals

ATTACHMENT B (continued)

Clean Hands Save Lives! Remember to Gel In and Gel Out!

When hands are visibly soiled, use soap and water.

Background

For over 150 years, scientists have associated decreased morbidity and mortality rates with the practice of cleaning one's hands. Studies show hand hygiene contributes to reductions in healthcare-associated infections.
Healthcare workers report various factors contributing to poor compliance with hand hygiene, including, but not limited to:

- Working in an Intensive Care Unit (ICU)
- Wearing of gloves eliminates the need
- Hand dryness or irritation
- Inconvenient sink location
- Lack of soap/paper towels

If hand hygiene is to improve, it is essential to eliminate barriers associated with these factors. Barriers include:

- Lack of hand hygiene guideline knowledge
- Failure to recognize hand hygiene opportunities during the performance of one's duties
- Lack of awareness for the risk for cross-transmission of organisms

On the average, studies reveal it takes about 62 seconds to complete the cycle from finishing a patient task, to washing hands, to returning to patient care activities. Removing barriers requires efforts to make hand hygiene easily accessible, time saving, and contribute to improved skin condition. Use of the recommended 1-3 ml alcohol handrub solution takes about 25-30 seconds. You will save time using alcohol handrubs!

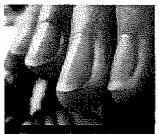
Hand Hygiene Recommendations

Wash Hands with Plain or Antimicrobial Soap:

- When visibly dirty
- When contaminated with proteinaceous material
- When contaminated with blood or body fluids
- Before eating or handling food
- After using the restroom

Decontaminate Hands with Alcohol Handrubs:

- When NOT visibly soiled
- Before direct patient contact
- Before donning sterile gloves to insert central intravascular lines
- Before inserting urinary catheters, other IV catheters, OR invasive devices not require surgical placement
- After contact with patients intact skin
- After contact with mucous membranes or non-intact skin if hands are not visibly soiled
- After removing gloves
- If moving from a contaminated body site to a clean body site during care
- After contact with objects (including equipment) located in the patient's environment



Remember to keep nails trim and clean.
No artificial nails if you have direct patient contact.

Fingernails- Keeping it Real

Thousands of pathogenic organisms can survive under and round fingernails. Clean areas under fingernails if they are visibly dirty, and pay special attention to these areas when you wash OR use alcohol handrubs for cleaning hands. Freshly applied nail polish does not increase the number of germs present, but chipped nail polish may harbor bacteria. Persons with artificial nails may be more likely to harbor higher bacterial counts than those who do not wear them. Keep them short and real.
TRMC Policies: 15-2028 Code of Personal Appearance and 20-8025 CDC Hand Hygiene Guidelines.

Hand Hygiene Techniques

Hand Washing with Plain or Antimicrobial Soap

Purpose: Physical removal of soil and transient micro-organisms, including bacterial spores.

- Wet hands with water.
- Apply soap to hands, according to manufacturer's directions.
- Rub hands vigorously together for at least 15 seconds.
- Cover entire surface of hands and fingers.
- Rinse hands well to remove soap residue.
- Dry with paper towel.
- Use towel to turn off faucet.

Hand Hygiene with Alcohol-Based Handrub

Purpose: Reduction of bacterial counts on hands when hands are NOT visibly soiled.

- Apply product to palm of one hand.
- Rub hands together.
- Cover all surfaces of hands and fingers.
- Rub until hands are dry.

Surgical Hand Antisepsis with Antimicrobial Soap or Alcohol-Based Handrub

Purpose: Elimination of transient microorganisms and reduction of resident hand flora, performed prior to surgical procedures, before donning sterile gloves.

- Remove rings, watches and bracelets before beginning surgical hand scrub.
- Use a nail cleaner and running water to remove debris from under fingernails.
- When using antimicrobial soap, scrub for at least 2-6 minutes, or as recommended by the manufacturer.
- When using an alcohol-based surgical hand scrub product with persistent activity, prewash hands and forearms with a nonantimicrobial soap:
  1. Dry hands and forearms completely.
  2. Apply alcohol-based product as recommended.
  3. Allow hands and forearms to dry completely.
  4. Don sterile gloves.

ATTACHMENT C
(Hand Hygiene Competency (CAT)

Tulare Regional Medical Center
HAND HYGIENE

COMPETENCY ASSESSMENT TOOL

ASSESSMENT KEY:
1 = Unable to Perform
2 = Performs with Assistance
3 = Performs Independently
N/A = Not Applicable

Name:_____

Employee #: _____

Orientation Period: _____

DEMONSTRATES COMPLIANCE WITH HOSPITAL REGULATIONS RELATING TO PROVIDING NURSING CARE FOR THE PATIENT CRITERIA	Self Eval	Competency Performed # DATE INITIALS	Competency Performed # DATE INITIALS	Competency Performed # DATE INITIALS	Comments
Alcohol-based hand rub when hands **are not** visibly soiled – decontamination:					
a) Apply product to palm of hand, rub hands together, covering all areas of the hands and fingers, until hands are dry. **b)** Follow the manufacturer's recommended guidelines for the amount of alcohol-based hand rub.					
Use antimicrobial soap and water or non-antimicrobial soap and water when hands **are** visibly soiled.					
1. Keep clothing away from sink and splashes.					
2. Wear minimal jewelry.					
3. Keep nails short (1/4 inch in length). No artificial nails or extenders when having direct contact with patients.					
4. Turn on water and adjust temperature for your comfort.					
5. Wet hands and apply manufacturer's recommended amount of soap to hands. Lather well (soap and friction reduces surface tension enabling the removal of bacteria).					

CRITERIA	Self Eval	Competency Performed # DATE INITIALS	Competency Performed # DATE INITIALS	Competency Performed # DATE INITIALS	Comments
6. Clean fingernail area (bacteria may be harbored beneath fingernails).					
7. Wash hands thoroughly, using rigorous scrubbing action for at least 15 seconds. Work lather around fingernails, top of hands, etc.					
8. Rinse hands and wrists under running water.					
9. Repeat hand-hygiene technique, if necessary (to prevent recontamination of hands).					
10. Dry hands with clean paper towel. (Multiple use towels, i.e., rolling towels, are not recommended for healthcare facilities.)					
11. Turn off faucets with used paper towel and discard.					
12. Avoid using hot water for hand-hygiene. Repeated use of hot water may increase the healthcare worker's risk of dermatitis.					
Surgical Hand Antisepsis (OR, OB and Cath Lab)					
1. Remove rings, watches and bracelets before beginning a surgical hand scrub.					
2. Remove debris under the fingernails using a nail cleaner.					
3. Use surgical hand antisepsis every time before donning sterile gloves and performing procedures.					
4. Use an antimicrobial soap with a **persistent activity,** scrub hands and forearms for length recommended by the manufacturer (usually 2-6 minutes).					

ATTACHMENT C (continued)

5. If using an alcohol-based surgical hand care product with **persistent activity**, use manufacturer's instructions. Pre-wash hands and forearms with non-antimicrobial soap, dry and then apply the alcohol-based product. Dry before donning gloves.					

METHOD:
DO =Direct Clinical Observation
OT =Oral Test
SLD=Skills Lab Demonstration
WT =Written Test
V+T=Videotape plus Test

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: CDC Hand Hygiene Guidelines

Descriptive Type: Revised

Document Number: 20-8025

Attachments: Attachments A, B, C

Author: Josh Warren

Typist: Maritza Sevillano

Creation Date: 02/23/12

Revision Date: 4/16/18

Prev. Dist. Date: 05/24/12

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	N/A	Date change only
MEC	N/A	Date change only
Board of Directors	N/A	

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Outbreak Management Plan

DEFINITION:

An Outbreak is the occurrence of more cases of a disease than expected during a specified period of time in a given area or among a specified group of people. In a healthcare facility, an outbreak may be suspected when routine surveillance activities detect an unusual microbial isolate, a cluster of cases or an apparent increase in the usual number or incidence of cases.

PURPOSE:

An outbreak investigation (whether basic or full scale) will define the source, determine the mode of transmission and implement measures to prevent and control further spread of additional cases.

PROCESS:

The most important reason to investigate a recognized outbreak of disease is to reduce further exposure from the source(s) of infection (which may be still occurring) by prompt identification and control. A standard process is followed to assure all components are met and the important steps are completed.

A. Attachments:

1. ***Process for Outbreak Management*** – displays the step-by-step details of performing an outbreak investigation from surveillance, development of a case definition, literature research, development and testing of a hypothesis, and evaluation of control measures (Appendix A).
2. ***Sample Line List*** – a grid for recording demographic data for patients/ healthcare workers with illness or exposed to illness and at risk for developing signs and symptoms of infection (Appendix B).

Effective Date: 10/01/15 (20) Clinical Guidelines
Infection Control:
Outbreak Management Plan
20-8027

APPROVED:

Medical Executive Comm.: 09/09/15

Board Of Directors: 09/30/15

3. ***Sample Employees Seen/Treated*** – a grid for recording demographic data for employees who were evaluated and/or treated for their exposure to a given microbial agent causing an outbreak (Appendix C).

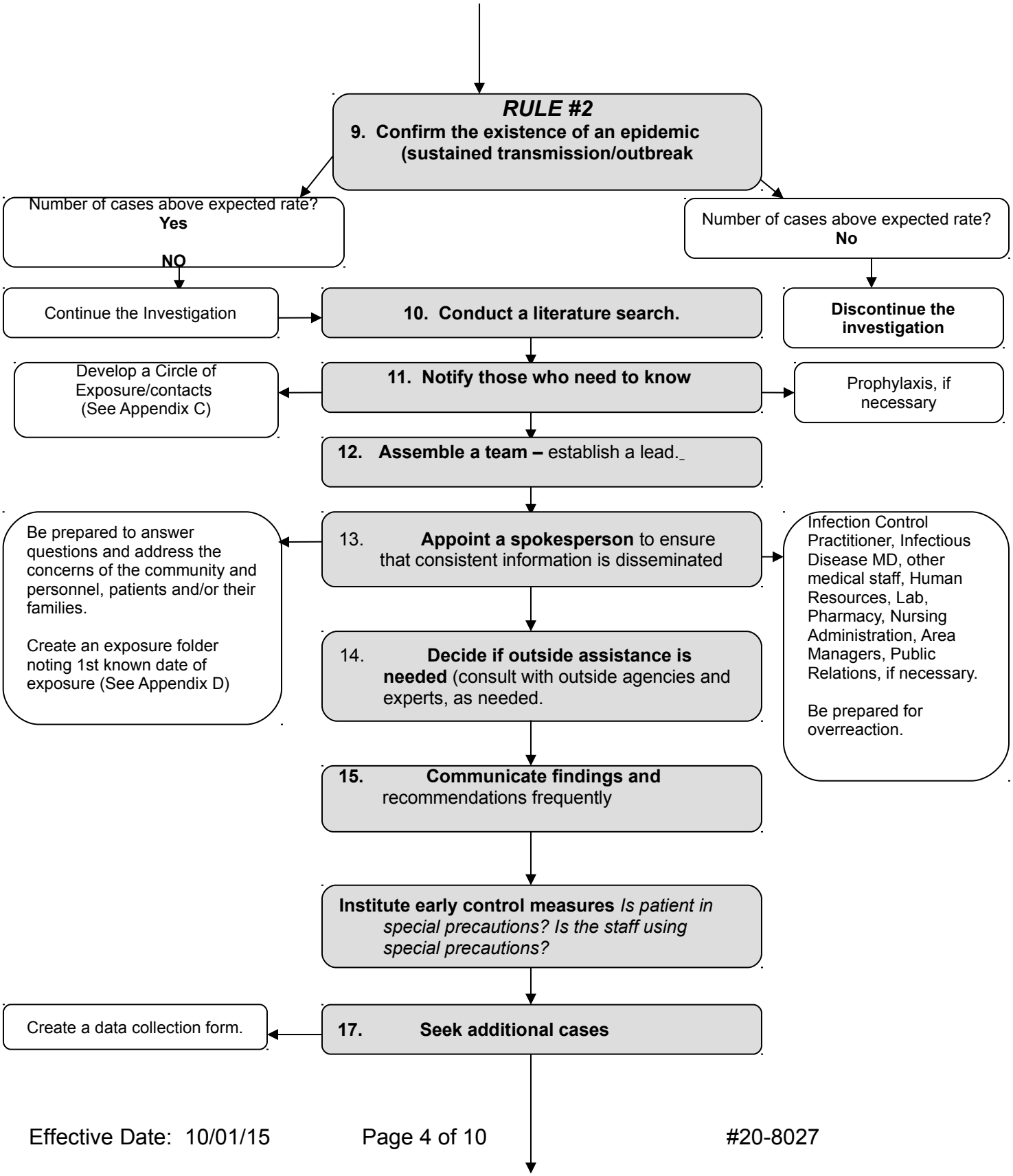
4. ***Circle of Exposure*** – a reference tool that displays the means by which an outbreak starts with an index case or source and then is transmitted outwardly through concentric circles of contacts with varying levels of contact to the source from close to remote (Appendix D).

5. ***Exposure Record*** – a form that must be completed with each outbreak of disease. The form effectively gathers the details of the outbreak in a summary format. The information gleaned from analysis of the exposure record provides clues and direction toward future prevention practices that if implemented may reduce future outbreak events from occurring (Appendix E).

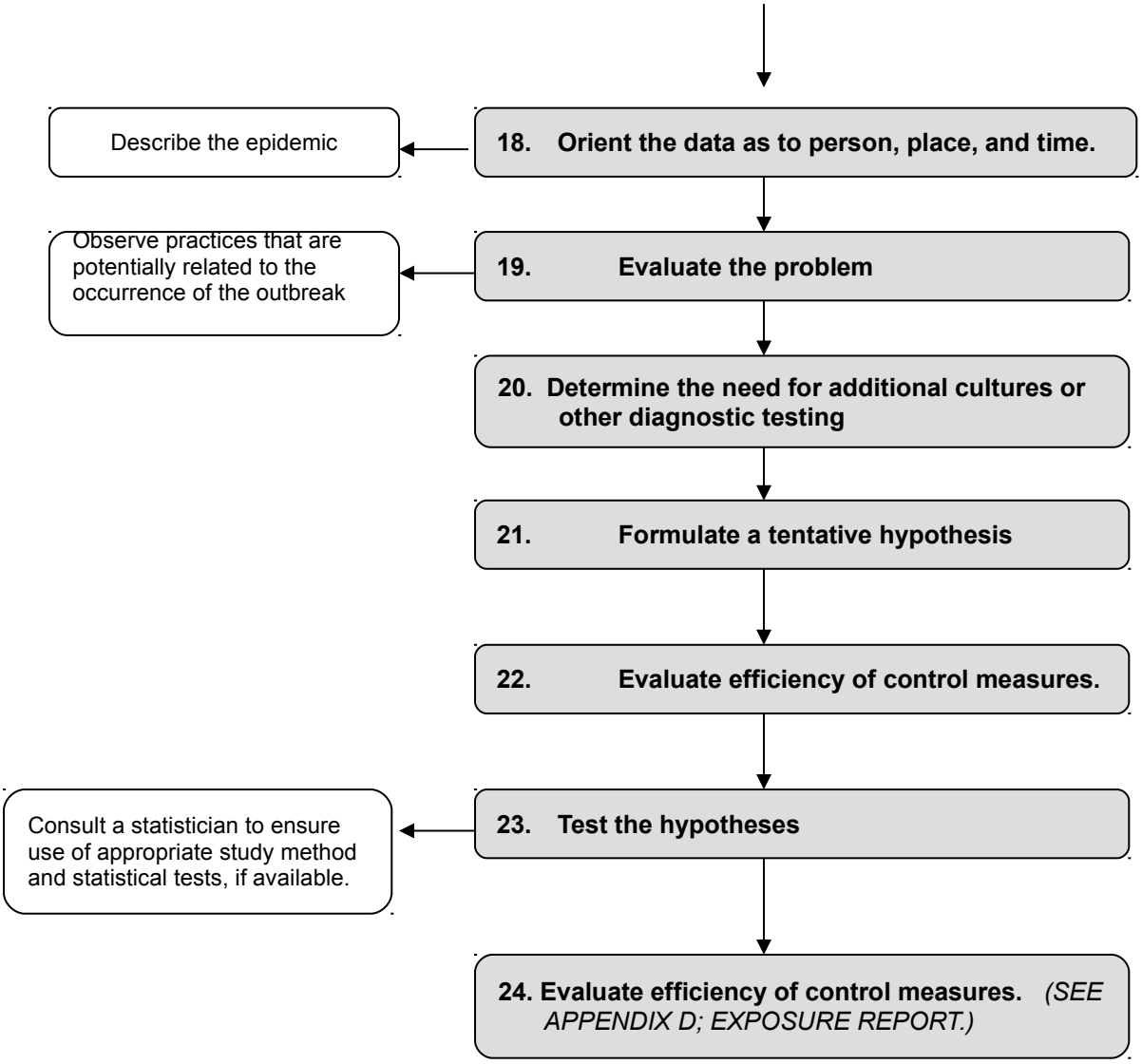
6. ***Outbreak Communication Tree*** – a flowchart that displays the appropriate channels of notification when there is suspicion or evidence of an outbreak (Appendix F).

The following is the recommended process for Outbreak Management:

(Continued)


RULE #2
9. Confirm the existence of an epidemic (sustained transmission/outbreak
Number of cases above expected rate? Yes
NO
Number of cases above expected rate? No
Continue the Investigation
10. Conduct a literature search.
Discontinue the investigation
Develop a Circle of Exposure/contacts (See Appendix C)
11. Notify those who need to know
Prophylaxis, if necessary
12. Assemble a team – establish a lead.
Be prepared to answer questions and address the concerns of the community and personnel, patients and/or their families.
Create an exposure folder noting 1st known date of exposure (See Appendix D)
13. Appoint a spokesperson to ensure that consistent information is disseminated
Infection Control Practitioner, Infectious Disease MD, other medical staff, Human Resources, Lab, Pharmacy, Nursing Administration, Area Managers, Public Relations, if necessary.
Be prepared for overreaction.
14. Decide if outside assistance is needed (consult with outside agencies and experts, as needed.
15. Communicate findings and recommendations frequently
Institute early control measures Is patient in special precautions? Is the staff using special precautions?
Create a data collection form.
17. Seek additional cases

(Continued)



MANY OF THESE STEPS WILL OCCUR SIMULTANEOUSLY

References:

1. All current CDC Guidelines for Prevention, Control, and Recommendation for specific outbreaks.

2. Quick Reference to Outbreak Investigation and Control in Health Care Facilities; Arias, Kathleen, Aspen, 2000. Chapter 8, Page 161-180.

(SAMPLE) LINE LISTING

APPENDIX B

NAME	RECORD NUMBER	AGE	SEX	UNIT(S)	ROOM NUMBER	DATE OF ADMISSION	DATE OF ONSET	SERVICE	SIGN & SYMPTOMS	TYPES OF THERAPY	SURGERY	DATE & RESULTS OF LAB	OTHER

APPENDIX C

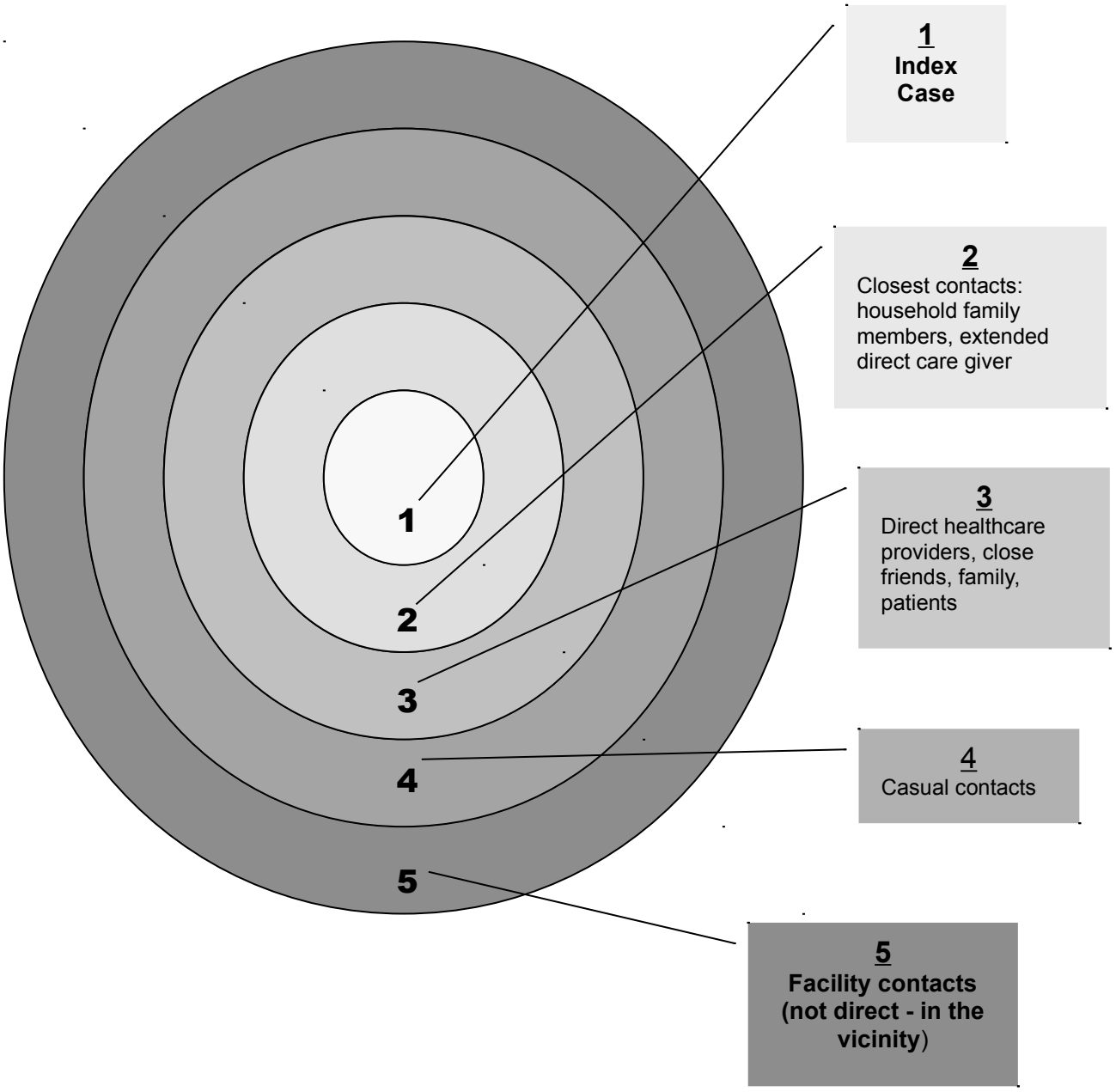
TULARE REGIONAL MEDICAL CENTER

SAMPLE
EMPLOYEES Seen or Treated

Issue:_____

EMPLOYEE	DEPT.	CONTACT INFORMATION SEEN BY Employee Health Physician and/or ED Fast Track	COMMENTS	Proph X	Possible	Probable	Definite
1							
2							
3							
4							

CIRCLE OF EXPOSURE
APPENDIX C



APPENDIX D

APPENDIX E

EXPOSURE RECORD

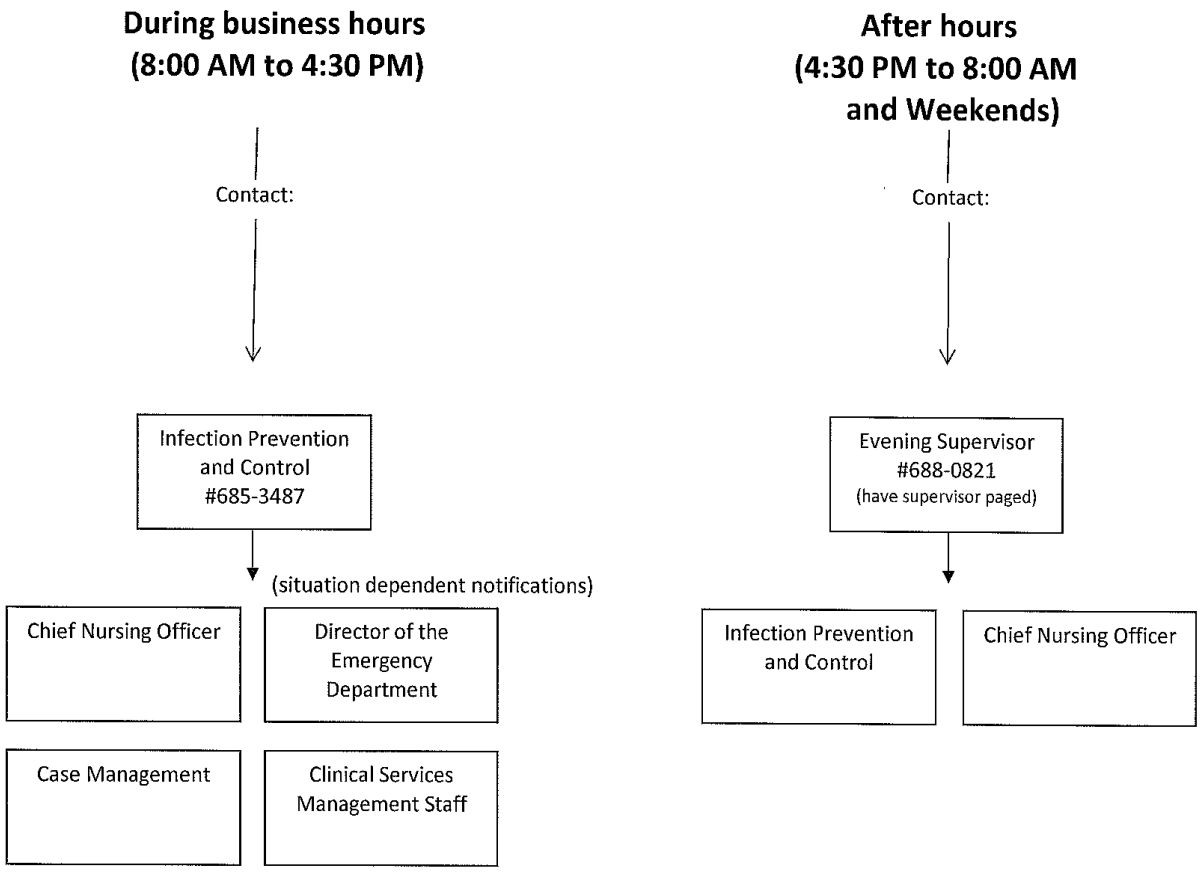
TYPE OF EXPOSRURE:	
DATE OF OCCURRENCE:	**REPORT DATE:**
BACKGROUND ASSESSMENT:	
IMPRESSION:	
ACTION:	
IDENTIFIED ISSUE	

PLAN	IMPLEMENTATION	EVALUATED

POLICY / GUIDELINE

APPENDIX F:

Outbreak Notification Tree



Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Descriptive Name: Outbreak Management Plan

Descriptive Type: Revised

Document Number: 20-8027

Attachments: Yes

Author: Josh Warren

Typist: Maritza Sevillano

Creation Date: 01/26/12

Revision Date: 04/17/18

Prev. Dist. Date: 05/24/12

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	N/A	Date change only
MEC	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: MRSA Active Surveillance Testing (AST) Policy

I. PURPOSE

Identify the patient populations eligible for active surveillance testing (AST) for Methicillin-Resistant *Staphylococcus aureus* (MRSA) in compliance with the California Health and Safety Code; and to outline the process for specimen collection, patient education and notification of test results

II. POLICY

A. Tulare Regional Medical Center shall comply with the requirements for MRSA AST according to California Health and Safety Code Sections 1255.8 and 1288.55.

B. All patients meeting the following criteria will undergo MRSA AST within 24 hours of admission:

1. Patients undergoing surgery with increased risk of infection: Hip Arthroplasty and Knee Arthroplasty.

2. Admitted patients who have been documented as discharged from an acute care facility within the last 30 days.

3. Patients who will be admitted to the ICU, including transfers from another unit.

4. Admitted patients receiving inpatient dialysis treatment. Patients who have received dialysis during their admission will also have a MRSA screening done at discharge. This is done in accordance with senate bill 1058.

5. Admitted patients transferred from a skilled nursing facility.

C. Once converted from an observation/outpatient status to an inpatient; the patient must be tested within 24hours if any of the above criteria are met.

D. All ICU patients who have never tested positive for MRSA and have been inpatients greater than 7 days will undergo MRSA testing prior to transfer or discharge. (See ~~References on page 3~~Attachment D)

III. PROCEDURE

A. Patient identification:

1. Screening to identify patients meeting testing criteria will occur upon admission to the hospital and upon transfer to the ICU.

2. Patients meeting testing criteria identified through the admission process on the nursing units. Daily monitoring will be done.

3. Standard MRSA Screening Orders will accompany every admission pack. (See Attachment D):

   a. The nurse will screen patient's status against the criteria for MRSA active surveillance testing (AST).

   b. If the patient does not meet criteria for AST the nurse will check-mark the box next to testing not indicated and shall sign, date, and time the entry on the form. The form is to be left in the chart.

   c. If the patient does meet the criteria for AST the nurse will check-mark the box next to the criteria that applies to the patient's status making them eligible for AST. The nurse shall sign, date, and time the entry on the form. The form is to be left in the chart. The physician attending to the patient shall sign, date, and time the order within 24 hours of its implementation.

4. Patients who have documented positive results will not be tested subsequently.

.

5. Patients will be surveillance tested no more than once per admission

6. Selected patients will be informed by the nurse the reasons behind nasal testing and expected procedure.

7. Patients refusing testing will be documented in the patient's record.

B. Patient testing:

1. Nursing will obtain a nasal swab specimen for testing and submit to laboratory as follows:

a. Physician will order the MRSA nasal culture. (See pre-printed order Attachment D).

b. Nurse will collect the culture (must be obtained within 24 hours of admission).

i. Use a routine culture swab.

ii. Insert sterile, dry swab 1-2cm into the right nostril and gently rotate swab against the inside of the nostril for 3 seconds (enough pressure should be used when swabbing the nares, that it is a tickling sensation and not painful).

iii. Using the **same swab**, repeat step 2 in the left nostril.

iv. Place swab back into the transport media tube and label MRSA NARES along with Patient Label.

v. Order MRSA in computer ordering system.

vi. Send one culture per patient, DO NOT send multiple cultures.

vii. Send specimen and requisition to the lab.

viii. Results will follow in 24 hours.

2. Nile's Law (SB 1058):

a. See Nile's Law (SB 1058) Poster - Attachment A.

C. Patient notification:

1. The Physician will inform the patient or the patient's representative about the results as soon as possible.

D. Quality Control:

1. Infection Prevention & Control will receive both positive and negative results, and will log and analyze these results on a continual basis.

E. Although not part of MRSA AST, patients with MRSA positive results will be provided with oral and written instruction on aftercare and prevention of MRSA transmission.

1. See Attachment B & C MRSA Patient Education Information (English & Spanish).

~~F. The Tulare Regional Medical Center Education-Infection Control Intranet website can be accessed for educational materials.~~

IV. DEFINITIONS

A. "MRSA" means Methicillin-Resistant *Staphylococcus aureus*.

B. “AST” means active surveillance testing

V. REFERENCES

APIC (2007). Guide to Elimination of Methicillin-Resistant Staphylococcus aureus (MRSA) Transmission in Hospital Settings

CDC (2006). Management of Multi-Drug Resistant organisms in Healthcare Settings Retrieved 1/30/2009: http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html

SB 1058 Bill: http://info.sen.ca.gov/pub/07-08/bill/sen/sb1051-1100/SB1058Bill_20080925chaptered.pdf

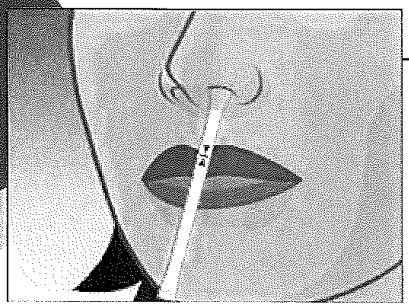
Local San Joaquin Association of Professional in Infection Control Chapter consensus on 11/19/10 re: New legislation for MRSA screening prior to discharge for patients at greater risk for invasive MRSA infection.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Tulare Regional Medical Center

Nile's Law (SB 1058)



Effective January 1, 2009, California hospitals are required to implement certain procedures related to health care associated infections. Nile's Law (SB 1058) requires Methicillin-Resistant Staphylococcus (MRSA) testing within 24 hours of admission. Below is the list of patients that will require MRSA nasal swabbing by the RN once the patients are admitted:

S = Scheduled for surgery and with Hip or Knee Arthroplasty

T = Transferred from a skilled nursing facility

I = Intensive Care Unit Patients (includes all transfers & direct admits, NICU)*

R = Re-admission patients within 30 days prior to current admission

D = Dialysis (peritoneal and hemodialysis patients) **Only** if they have one of the above

* All ICU patients who have never tested positive for MRSA and have been inpatient greater than 7 days will undergo MRSA testing prior to transfer or discharge.

Process that each RN must follow to comply with Nile's Law (SB 1058):

1. Nursing will obtain a nasal swab specimen for testing and submit to laboratory as follows:

*Physician will order the MRSA nasal culture through Standard MRSA Screening Order available with in each Admission Pack.

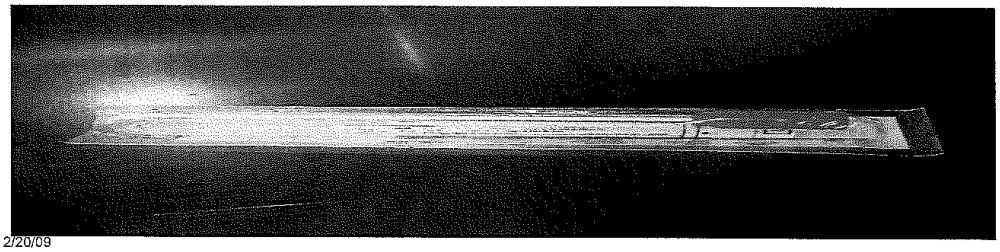
*Nurse will collect the culture. (Must be obtained within 24 hours of admission).

1. Use a routine culture swab.
2. Insert sterile, dry swab 1-2cm into the right nostril and gently rotate swab against the inside of the nostril for 3 seconds (enough pressure should be used when swabbing the nares, that it is a tickling sensation and not painful).
3. Using the **same swab**, repeat step 2 in the left nostril.
4. Place swab back into the transport media tube and label MRSA NARES along with Patient Label.
5. Order MRSA in **computer ordering system**.
6. Send one culture per patient, **DO NOT** send multiple cultures.
7. Send specimen and requisition to the lab.

Patient notification

The Physician will inform the patient or the patient's representative about the results as soon as possible.

Send ONE culture per patient, DO NOT send multiple cultures!



Developed 2/20/09
Revised 4/1/11

M:\infection prevention & control 2010\mrsa 2010\mrsa patient education 2.20.09.pub

Attachment A

MRSA PATIENT EDUCATION INFORMATION /
INFORMACIÓN EDUCATIVA SOBRE MRSA PARA LOS PACIENTES

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274 • 559.688.0821 • www.TulareRegional.org

Methicillin-resistant Staphylococcus aureus (MRSA) Testing Adults California state law now requires hospitals to test certain patients for a germ called MRSA.

- What is MRSA?
  Staphylococcus aureus or "staph" is a common germ that about 1 out of every 3 people normally has on the skin or in the nose without it causing any problem. MRSA is a type of staph that is not killed by penicillin or similar antibiotics, the drugs most commonly used to treat staph infections.

- What does the result of this test mean?
  If the test is positive, it means that at the time your nose was swabbed, MRSA was present. You are considered "colonized" with MRSA. If the test was negative, it means that you are not "colonized" with MRSA.

- What does "colonized" mean?
  If you are colonized with a germ, it means that the germ is on your body. In most cases, it does not make you sick.

- What is the difference between being colonized and having an infection?
  If you have an infection, you are usually sick and your doctor will give you treatment of some kind for the infection. If you are colonized, you are not sick and no treatment is necessary.

- What should I do if I am told that my test is positive?
  Carry on with your daily life as usual. If your test is positive, there are simple things listed below that you can do to help prevent MRSA from causing you problems.

- What are some things that hospitals are doing to prevent MRSA infections?
  To prevent MRSA infections, doctors, nurses and other healthcare providers:
  - **Clean their hands** with soap and water or an alcohol-based rub before and after caring for every patient.
  - **Clean hospital rooms** and medical equipment.

- What can I do to prevent infections including MRSA?
  Infections are caused by germs entering your body through an opening in your skin (a cut or scrape) or through mucous membranes (eyes, nose, and mouth). Clean hands and a clean environment are key to preventing the spread of germs in any environment. These few simple things will help prevent infections with most germs.

  In the hospital:
  - Watch for hand hygiene
  - **If you do not see your providers clean their hands, please ask them to do so.**
  - Ask your visitors to clean their hands when they enter your room and before they leave.

  At home:
  - Clean your hands regularly (before eating, preparing food and after using the bathroom).
  - If you have wounds or an IV (catheter or port), make sure that you know how to take care of them.
    - Clean your hands often.
    - Keep any wounds clean and change bandages as instructed until healed.
  - Routinely clean the surfaces you touch frequently. Use a commercial wipe or soap and water.

- What should I do if I have an infection?
  Routine cleaning of your hands and your environment is the best way to prevent the spread of your infection to others.

Thank you for reminding our staff to clean their hands!
Tulare Regional Medical Center Department of Infection Prevention 559.685.3487
Reference: UCSF Dept of Epidemiology and Infection Prevention & Control 1/2009

Form O # 1725 REV. 6/10

Attachment B

**MRSA PATIENT EDUCATION INFORMATION /
INFORMACIÓN EDUCATIVA SOBRE MRSA PARA LOS PACIENTES**

Tulare Regional Medical Center
869 N. Cherry St. • Tulare • CA • 93274 • 559.688.0821 • www.TulareRegional.org

La ley del estado de California sobre la prueba del Staphylococcus aureus (estafilococo dorado) resistente a la meticilina (MRSA, por sus siglas en inglés) exige actualmente que los hospitales realicen la prueba de detección de una bacteria denominada MRSA en determinados pacientes.

- ¿Qué es MRSA?
  El Staphylococcus aureus o "estafilococo dorado" es una bacteria común que aproximadamente 1 de cada 3 personas tiene, por lo general, en la piel o en la nariz, sin causar problemas. MRSA es un tipo de estafilococo resistente a la penicilina o a antibióticos similares, los medicamentos que se utilizan más comúnmente para tratar las infecciones por estafilococos.
- ¿Qué significa el resultado de esta prueba?
  Si el resultado de la prueba es positivo, significa que la bacteria MSRA estaba presente en el momento en que se obtuvo la muestra con hisopo de su nariz. Por lo tanto, se lo considera "colonizado" por MRSA. Si el resultado de la prueba es negativo, significa que usted no está "colonizado" por MRSA.
- ¿Qué quiere decir "colonizado"?
  Si usted está "colonizado" por una bacteria, esto quiere decir que la bacteria está en su organismo. En la mayoría de los casos, esto no lo hace estar enfermo.
- ¿Cuál es la diferencia entre estar colonizado y tener una infección?
  Si usted tiene una infección, por lo general se siente enfermo y su médico le indicará un tratamiento para combatir la infección. Si usted está colonizado, no está enfermo y no necesita realizar un tratamiento.
- ¿Qué debo hacer si se me informa que el resultado de mi prueba es positivo?
  Continúe con su vida diaria como de costumbre. Si su prueba tuvo un resultado positivo, existen cosas sencillas que enumeramos a continuación que puede hacer para ayudar a evitar que el MRSA le ocasione problemas.
- ¿Cuáles son algunas de las medidas que los hospitales implementan para evitar las infecciones por MRSA?
  Para evitar las infecciones por MRSA, los médicos, las enfermeras y otros proveedores de atención méd
  - **Se lavan las manos** con agua y jabón o con una loción a base de alcohol para restregar las man antes y después de atender a cada paciente.
  - **Limpian los cuartos de los hospitales** y el equipo médico.
- ¿Qué puedo hacer para evitar infecciones, incluida la del MRSA?
  Las infecciones son ocasionadas por bacterias que ingresan en su organismo a través de una abertura en la piel (como un corte o rasguño) o a través de las membranas mucosas (ojos, nariz, boca). Las manos limpias, así como un entorno limpio, son medidas clave para evitar la propagación de bacterias en cualquier lugar. Estas medidas sencillas ayudarán a prevenir infecciones causadas por la mayoría de las bacterias.
  En el hospital:
  - Esté pendiente del lavado de las manos.
  - **Si usted no ve que sus proveedores se lavan las manos, pídales que lo hagan.**
  - Pida a sus visitantes que se laven las manos cuando entren a su habitación y antes de salir de ella.

  En el hogar:
  - Lávese las manos con frecuencia (antes de comer, antes de preparar la comida y luego de usar el baño).
  - Si tiene heridas o un catéter o puerto intravenoso, asegúrese de saber cómo cuidarlos.
    - Lávese las manos con frecuencia.
    - Mantenga las heridas limpias y cambie las vendas conforme las indicaciones que le hayan dado, hasta que cicatricen.
  - Limpie habitualmente las superficies que toca con frecuencia. Utilice un paño comercial o agua y jabón.
- ¿Qué debo hacer en caso de tener una infección?
  La limpieza habitual de las manos y del entorno que habita es la mejor manera de prevenir que se propague la infección a otros.

¡Gracias por recordarles a los integrantes de nuestro personal que se laven las manos!
Departamento de Prevención de Infecciones del Tulare Regional Medical Center 559.685.3487
Referencia: Departamento de Epidemiología y Control y Prevención de Infecciones de la Universidad de California, San Francisco (UCSF) 1/2009

Form O # 1725 REV. 6/10

Attachment C

PHYSICIAN ORDERS

Tulare Regional Medical Center

Diagnosis
Drug Allergies

Another brand of drug identical in form And content may be dispensed unless checked. ☐

DATE: _____

TIME: _____

Standard MRSA Screening Order

In compliance with state Bill 1058 (Nile's Law) every patient fitting the criteria for MRSA screening will have a nasal culture performed to verify the presence of MRSA colonization **within 24 hours of admission** or verify evidence of increased risk for an invasive infection caused by MRSA **prior to discharge**.

The following criteria if met necessitates MRSA screening using a sterile dry swab inserted into both the right and left nostril and gently rotated for 3 seconds in each nostril. The swab shall be placed into transport media, labeled with patient's name and medical record, and the specimen and requisition form taken to lab. Final lab results will be reported in 24 hours.

Criteria: (Check the appropriate box that applies to MRSA screening for this patient **to be performed within 24 hours of admission**)

- ☐ Patient undergoing surgery for total knee or hip replacement
- ☐ Admitted patient who has been documented as discharged from an acute care facility within the last 30 days
- ☐ Patient admitted to the ICU or NICU, including a transfer from another unit
- ☐ Admitted patient receiving inpatient dialysis treatment
- ☐ Admitted patient transferred from a skilled nursing facility

Criteria: (Check the box below that applies to MRSA screening for patients with evidence of increased risk for invasive MRSA infection **to be performed prior to transfer or discharge**) *initiated January 1, 2011.*

- ☐ All **ICU patients** who have never tested positive for MRSA **and** have been inpatients **greater than 7 days** will undergo MRSA testing **prior to transfer or discharge**.

RN Signature _____ Date _____ Time _____

MRSA SCREENING

- ☐ Patient doesn't meet criteria for MRSA screening.

RN Signature _____ Date _____ Time _____

Physician Signature **Date** **Time**

Medical Executive Committee Approval:

PHYORD

M:\Infection Prevention & Control 2011\Policies 2011\Standard MRSA Screening Order form.doc

Attachment D

Descriptive Name: MRSA Active Surveillance Testing (AST) Policy

Descriptive Type: Revised Policy

Document Number: 20-8031

Attachments: Yes

Author: Joetta Denney

Typist: Melissa Arend

Creation Date: 02/24/11

Revision Date: ~~05/19/15~~4/9/18

Previous Dist. Date: 5/26/11

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	~~06/29/15~~	
MEC	~~09/09/15~~	
Board of Directors	~~09/30/15~~	

Effective Date: ~~10/01/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Identification and Triage, Testing, Management and Infection Control of Suspected and Confirmed Cases of Ebola Virus Disease (EVD)

Questions concerning any aspect of this policy/guideline should be referred to Infection Prevention and Control Department or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Purpose:
To standardize the identification, triage, transportation and management of patients with possible or confirmed Ebola Virus Disease (EVD) throughout Tulare Regional Medical Center (TRMC) and affiliates.

Abbreviations:
TRMC- Tulare Regional Medical Center
HCW- Healthcare Worker
ERC-Ebola Response Coordinator
EVD- Ebola Virus Disease
CDC- U.S. Centers for Disease Control and Prevention
CDPH- California Department of Public Health
WHO-World Health Organization
PUI- Person Under Investigation
TCHHS- Tulare County Health and Human Services
PHEP- Public Health Emergency Preparedness
DEETZ- Designated Ebola Evaluation and Treatment Zone
PPE- Personal Protective Equipment
HICS- Hospital Incident Command System
HERT- Hospital Ebola Response Team
FERRT- Federal Ebola Rapid Response Team
UCHS- University of California Health System

Definitions:
1. Healthcare worker (HCW): Any TRMC personnel, employees, temporary or contracted including students and volunteers. Physicians and licensed independent practitioners who practice at Tulare Regional Medical Center are addressed in Medical Staff Policy 1-007 “Communicable Disease Screening for Medical Staff and Allied Health Providers”.

2. Ebola Response Coordinator (ERC): A pre designated Healthcare worker with special expertise or training in Ebola Virus Disease (EVD), Infection Control, Infectious Disease Epidemiology, or Emergency Management who will serve as the primary point of contact for external agencies and/or the Hospital Incident Command System, as well as serving as the primary director of the clinical management of a suspected or confirmed Ebola patient by leading the HERT. This person may also jointly be appointed a position including Incident Commander under the Hospital Incident Command System.
3. Person Under Investigation (PUI): any person who exhibits both consistent symptoms and epidemiological risk factors as defined by most current CDC guidelines for Ebola Virus Disease.
4. Designated Ebola Evaluation and Treatment Zone (DEETZ): A securable and isolatable area to include one or more patient care areas that has been designated for Ebola case evaluation and treatment.
5. Personal Protective Equipment (PPE): Protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury of exposure.
6. Hospital Incident Command System (HICS): A systematized method of emergency management and response for healthcare facilities that assigns roles and responsibilities to coordinating persons and establishes a defined hierarchy of decision making. The HICS is led by the Incident Commander. Procedures detailed in Policy # 21-2014: Plan to manage the influx of Potentially Infectious Patients
7. Hospital Ebola Response Team (HERT): A group of voluntarily identified Healthcare workers of various specialties, led by the Ebola Response Coordinator, who have agreed to directly treat, manage, care for or otherwise directly coordinate hospital response and management of a suspected or confirmed Ebola Virus Disease patient, including such work as may require the use of appropriate Personal Protective Equipment.
8. Point of Care testing: Laboratory services provided at the bedside or in the immediate vicinity of patient care. Such services may be limited by equipment and supplies available, as well as staff trained to perform alternative or “manual” assays in place of more advanced methods available in a clinical lab.

Introduction and Commitment:

TRMC is committed to caring for those in need, regardless of illness. With such a mission in mind, patient and employee safety is a number one priority for this organization. TRMC is committed to providing a safe environment for all patients, staff and visitors at its facilities. Additionally, the U.S. Centers for Disease Control and Prevention (CDC) recommends that all hospitals in the United States be prepared to identify and care for patients who do or could have EVD.

TRMC will provide access to services without discrimination based on age, race, ethnicity, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, or source of payment. Additionally, TRMC will conduct risk assessment of patients with recent travel history to a country or region where EVD is present or who may have been exposed to EVD based upon other identified epidemiological risk factors.

Risk Assessment:

TRMC will conduct risk assessment for patients entering TRMC facilities through numerous routes including but not limited to:

1. Transfers from an outside facility or healthcare agency
2. Emergency Department
3. Walk-ins to facility
4. Labor and Delivery

5. Ambulatory Clinical care settings
6. Rural health Clinics

Details of risk assessment to be performed are addressed in (IV) Identification and Triage of Suspected or Confirmed EVD Cases.

About Ebola:

Ebola Virus Disease (EVD) is a viral hemorrhagic fever caused by a virus of the genus *Ebolavirus,* family *Filoviridae*. Ebolavirus is spread primarily by direct contact with blood or body fluids of infected and symptomatic persons and blood, saliva, sweat, vomitus, feces, urine and semen are among the infectious body fluids recognized at this time. Illness is characterized by an incubation period of 2-21 days, followed by high temperature, vomiting, abdominal pain, diarrhea, and other symptoms. Case fatality rate is between 25-90%. There are currently no FDA approved treatments for Ebola virus and supportive therapy including electrolyte management and aggressive rehydration is recommended.

Discovered in 1976 in the Democratic Republic of Congo, the virus was previously only known to cause small, localized outbreaks in isolated, rural areas of West Africa with fatality rates as high as 90%. In 2013-2014 a widespread outbreak of Ebola virus developed in the West African Countries of Liberia, Sierra Leone, and Guinea, with smaller clusters in a number of other countries including the United States. As of November 2014, nearly 14,000 cases and 5,000 deaths have been reported.

The purpose of this policy is to outline strategies for identification, testing and confirmation, management and infection control of suspected and confirmed Ebola Virus Disease cases at Tulare Regional Medical Center. Major Public Health authorities including the CDC, CDPH, WHO, and others have released numerous guidance documents that will be referenced repeatedly throughout this policy. Because of the fast changing nature of this widespread outbreak, it is important that only the most current guidance documents be implemented in relation to this policy and therefore any specific document referenced in this policy should be assessed for available updates before implementation and any attachments to this policy should not be immediately accepted as up-to-date.

This policy is divided as follows:

I. Case Definition of Ebola Virus Disease (EVD)

II. Symptomology and Epidemiological Risk Factors

III. Recommended Therapy and Treatment

IV. Designation of Facilities and Personnel

V. Identification and Triage of Suspected or Confirmed EVD Cases

VI. Notification of and Collaboration with Public Health Authorities and Healthcare Providers

VII. Isolation and Infection Control of Suspected or Confirmed EVD Cases

I. Case Definition of Ebola Virus Disease (EVD)

A. Definition of a Person Under Investigation (PUI)

CDC has defined Persons Under Investigation (PUI) as a person who exhibits both consistent symptoms and risk factors as follows:

1. Elevated body temperature or subjective fever or symptoms, including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage; AND

2. An epidemiologic risk (http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html) factor within the 21 days before the onset of symptoms

Reference: http://www.cdc.gov/vhf/ebola/hcp/case-definition.html

*__Affected Areas Reference:__ http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html#areas

B. Definition of Exposure Risk Levels

1. **High risk** includes any of the following:

- Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of a person with Ebola while the person was symptomatic
- Exposure to the blood or body fluids (including but not limited to feces, saliva, sweat, urine, vomit, and semen) of a person with Ebola while the person was symptomatic without appropriate personal protective equipment (PPE) (http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

- Processing blood or body fluids of a person with Ebola while the person was symptomatic without appropriate PPE or standard biosafety precautions
- Direct contact with a dead body without appropriate PPE in a country with widespread Ebola virus transmission(http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)
- Having lived in the immediate household and provided direct care to a person with Ebola while the person was symptomatic

2. **Some risk** includes any of the following:

- In countries with widespread Ebola virus transmission(http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html):
    - direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic or with the person's body fluids
    - any direct patient care in other healthcare settings
- Close contact in households, healthcare facilities, or community settings with a person with Ebola while the person was symptomatic
    - Close contact is defined as being for a prolonged period of time while not wearing appropriate PPE within approximately 3 feet (1 meter) of a person with Ebola while the person was symptomatic

3. **Low (but not zero) risk** includes any of the following:

- Having been in a country with widespread Ebola virus transmission(http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html) within the past 21 days and having had no known exposures
- Having brief direct contact (e.g., shaking hands) while not wearing appropriate PPE, with a person with Ebola while the person was in the early stage of disease
- Brief proximity, such as being in the same room for a brief period of time, with a person with Ebola while the person was symptomatic
- In countries without widespread Ebola virus transmission: direct contact while using appropriate PPE with a person with Ebola while the person was symptomatic
- Traveled on an aircraft with a person with Ebola while the person was symptomatic

4. **No identifiable risk** includes:

- Contact with an asymptomatic person who had contact with person with Ebola
- Contact with a person with Ebola before the person developed symptoms
- Having been more than 21 days previously in a country with widespread Ebola virus transmission(http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html)
- Having been in a country without widespread Ebola virus transmission and not having any other exposures as defined above
- Aircraft or ship crew members who remain on or in the immediate vicinity of the conveyance and have no direct contact with anyone from the community during the entire time that the conveyance is present in a country with widespread Ebola virus transmission

Reference: http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html

C. Definition of a Confirmed EVD case

A case with laboratory-confirmed diagnostic evidence of Ebola virus infection.

Reference: http://www.cdc.gov/vhf/ebola/hcp/case-definition.html

II. Symptomology and Epidemiological Risk Factors

A. Symptomology

After sufficient exposure to blood or body fluids of an active EVD case, a susceptible person developing EVD will experience an asymptomatic incubation period of 2-21 days (with a mean of 8-10 days) before becoming infectious. Humans are not infectious until they develop symptoms. First symptoms are non-specific and generally include the sudden onset of fever (defined as greater than 38 degrees C or 100.4 degrees F) fatigue, muscle pain, headache and sore throat. Initial presentation is followed by gastrointestinal symptoms including vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes. Multiple organ failure, sepsis and death characterize late stages of EVD.

Reference: http://www.who.int/mediacentre/factsheets/fs103/en/

Reference:http://www.cdc.gov/vhf/ebola/ppt/ebola-101-cdc-slides-for-us-healthcare-workers.pptx

B. Epidemiological Risk Factors

Geographic and proximal epidemiological risk factors for EVD infection are defined as above and consist of contact with blood or other body fluids or human remains of a patient known to have or suspected to have EVD; residence in—or travel to—an area where EVD transmission is active*; or direct handling of bats or non-human primates from disease-endemic areas. Socioeconomic and demographic epidemiological risk factors are unclear at this time but extreme ages and immunocompromised persons are presumed to be at higher risk.

Reference: http://www.cdc.gov/vhf/ebola/exposure/risk-factors-when-evaluating-person-for-exposure.html

III. Recommended Therapy and Treatment

A. Recommended Therapy

Supportive care-rehydration with oral or intravenous fluids- and treatment of specific symptoms as deemed medically prudent, has been demonstrated to improve survival.

Reference: http://www.cdc.gov/vhf/ebola/treatment/index.html

B. Treatment

There are currently no FDA approved vaccines or immunizations available for EVD. Several potential treatments including blood products and vaccines are under expedited

consideration and experimentation by the FDA and other agencies. Limited success has been observed in transfusion of serum containing antibodies from serocompatible Ebola survivors into acute cases.

Reference: http://www.who.int/mediacentre/factsheets/fs103/en/

IV. Designation of Facilities and Personnel

A. Designated Ebola Evaluation and Treatment Zone (DEETZ)

Emergency Department 2 (at the Ambulance Bay) including adjoining offices and hallway (as depicted in Figure 1) is designated as the Ebola Evaluation and Treatment Zone for all TRMC facilities.

B. Hot Zone

The “Hot Zone” is designated as the Patient treatment room and adjoining restroom. The “Hot zone” will be utilized for patient evaluation and clinical care.

C. Warm Zone

The “Warm Zone” is designated as the remainder of Emergency Department 2 excluding adjoining offices and hallway. The “Warm Zone” will be utilized for storage of “dirty” equipment and bedside laboratory testing.

D. Cold Zone

The “Cold Zone” is designated as the adjoining hallway including security desk at Emergency Department 2 as well as adjoining restroom and ER Director Office. The Emergency Department 2 hallway proximal to the entrance doors is the designated PPE Donning/Doffing zone. The adjoining restroom is designated as the staff restroom and security desk is designated as Command and Control desk for the Hospital Ebola Response Team. The remaining adjoining hallway is designated for “clean” equipment and supply storage.

E. Medical Waste Holding Area

Medical Waste Holding area is designated as the adjoining storage room to Emergency Department 2 for small volumes of medical waste, and the external, gated and covered dumpster adjoining the Allied Services Building for large volumes of Ebola medical waste pending safe removal and disposal according to guidelines in (XII) Waste Management of Medical Waste for Suspected or Confirmed EVD Cases.

F. Hospital Ebola Response Team (HERT)

A Hospital Ebola Response Team (HERT) as defined above will be formed preferably consisting of the following individuals and/or specialties:

1. Infection Preventionist

2. Certified Critical Care Nurses
3. Emergency Preparedness Coordinator
4. Pharmacy Representative
5. Clinical Laboratory Representative
6. Environmental Services Representatives
7. Security Representatives
8. Engineering Representatives

The HERT will be responsible for rapid response and deployment to TRMC facilities in the event of notification through any method of the presence of a suspected or confirmed EVD case and will be responsible for coordinating and administering clinical care and infection control in conjunction with the designated officers of the activated HICS and collaborating authorities. The HERT will be under the direction of the Ebola Response Coordinator (ERC) with background as defined above.

V. Identification and Triage of Suspected or Confirmed EVD Cases

A. Identification and Risk Assessment of Suspected or Confirmed EVD cases

TRMC will conduct multi layered risk assessment for all patients with EVD compatible symptoms and epidemiological risk factors (including travel history) according to the following procedure:

B. At Security Desks:

For all walk-in patients and visitors seeking medical treatment at TRMC (without obvious injury):

1. Security staff will ask the question “Have you had any recent travel to West Africa?”.
2. If the patient or accompanying visitor responds “Yes” the security staff will ask that the individual remain at the Ambulance bay entrance
3. Immediately notify ER staff in Emergency Department 2 to clear the “Hot zone” room and move the individual to this room for clinical evaluation in this private, closed door environment.
4. If after clinical evaluation, the patient is designated a PUI, the HERT and HICS systems will be activated.
5. All potentially exposed persons will be contacted and evaluated according to the guidelines in (XIII) EVD Post Exposure Control Plan and Human Resources Considerations.

C. In all other clinical settings:

In all clinical settings at TRMC including Emergency Department, Ambulatory clinical care, Labor and Delivery, rural health clinics and so on:

1. Ebola risk assessment will be conducted according to the guidelines found in the CDC documents “Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States” (Attachment A) as well as “Ebola Virus Disease

Algorithm for Evaluation of the Returned Traveler" (Attachment B) for Emergency Department settings
2. In ambulatory Care settings including rural clinics, screening will be completed according to the CDC Document "Identify, Isolate, Inform: Ambulatory Care Evaluation of Patients with Possible Ebola Virus Disease (Ebola)" (Attachment C).
3. Screening and care guidelines for pregnant women with confirmed of suspected Ebola Virus Disease will be conducted according to CDC guidelines "Guidance for Screening and Caring for Pregnant Women with Ebola Virus Disease for Healthcare Providers in U.S. Hospitals" as referenced below.
4. These forms will be completed for each evaluated patient in conjunction with the TRMC document "Ebola Screening Flowsheet" (Attachment C) which guides risk assessment and initial isolation as well as notification of PUI cases.
5. Any patient meeting the screening and identification guidelines referenced in this policy will be considered a PUI and screening staff must immediately notify their clinical supervisor to activate the HICS and HERT systems for emergency response.
6. Immediate isolation of a qualifying PUI will take place according to Triage guidelines below depending on the applicable presentation scenario.

Reference: http://www.cdc.gov/vhf/ebola/pdf/checklist-patients-evaluated-us-evd.pdf

Reference: http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Reference: http://www.cdc.gov/vhf/ebola/pdf/ambulatory-care-evaluation-of-patients-with-possible-ebola.pdf

Reference: http://www.cdc.gov/vhf/ebola/hcp/guidance-maternal-health.html

D. Triage Scenarios for Suspected or Confirmed EVD Cases

Four possible scenarios exist for the Identification and Triage of Suspected or Confirmed EVD cases, as outlined below, each will result in activation of the Hospital Incident Command System (HICS) in accordance with Policy # 21-2014: Plan to manage the influx of Potentially Infectious Patients:

a. Scenario #1: Anticipated Identification of a Confirmed EVD case at TRMC

In the event of the anticipated arrival or identification of a Confirmed EVD case at TRMC the following actions will take place prior to the patient entering the campus grounds by ambulance or other conveyance:

1. The HICS will be activated and roles assigned
2. The HERT will be notified and assembled in the Ambulance Bay
3. All other patients in Emergency Department 2 will be evacuated and all new patients diverted from the Emergency Department 2 to Emergency Department 1.
4. The DEETZ will be secured; all entrances and exits locked and supervised entry only by security personnel.
5. The DEETZ will be cleaned by Environmental Services as time permits.

6. All necessary supplies will be assembled and checked for functionality in the DEETZ.
7. The HERT will supervise the secure transport of the Confirmed EVD patient to the DEETZ hot zone room and the initiation of isolation, evaluation and treatment according to guidelines in this policy.

b. Scenario #2: Anticipated Identification of a Suspected EVD case at TRMC

In the event of the anticipated arrival or identification of a Suspected EVD case (PUI) at TRMC the following actions will take place prior to the patient entering the campus grounds by ambulance or other conveyance:

1. The HICS will be activated and roles assigned
2. The HERT will be notified and assembled in the Ambulance Bay
3. All other patients in Emergency Department 2 will be evacuated and all new patients diverted from the Emergency Department 2 to Emergency Department 1.
4. The DEETZ will be secured; all entrances and exits locked and supervised entry only by security personnel.
5. The DEETZ will be cleaned by Environmental Services as time permits.
6. All necessary supplies will be assembled and checked for functionality in the DEETZ.
7. The HERT will supervise the secure transport of the Suspected EVD patient to the DEETZ hot zone room and the initiation of isolation, evaluation and confirmatory testing according to guidelines in this policy.

c. Scenario #3: Unanticipated identification of a Confirmed EVD case at TRMC

In the event of the unanticipated arrival or identification of a Confirmed EVD case at TRMC the following actions will take place:

1. Upon notification of any staff of the confirmed EVD status of the patient, the patient will be isolated in place, behind a closed door as feasible depending on current location, and all person traffic must be limited by security personnel. The Infection Preventionist and clinical supervisor must be notified immediately.
2. The HICS will be activated and roles assigned
3. The HERT will be notified and assembled in the Ambulance Bay
4. All other patients in Emergency Department 2 will be evacuated and all new patients diverted from the Emergency Department 2 to Emergency Department 1.
5. The DEETZ will be secured; all entrances and exits locked and supervised entry only by security personnel.
6. The DEETZ will be cleaned by Environmental Services as time permits.
7. All necessary supplies will be assembled and checked for functionality in the DEETZ.
8. Security will clear a path from the patients current location to the DEETZ
9. The HERT will don appropriate PPE as set forth in the guidelines “Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)”,

10. If Feasible, the HERT will contact the confirmed EVD patient and transport or escort the patient to the DEETZ according to guidelines set forth in (IX) Management of Suspected or Confirmed EVD Cases.
11. The HERT will supervise the secure transport of the Confirmed EVD patient to the DEETZ hot zone room and the initiation of proper isolation, evaluation and treatment.
12. Contact tracing and investigation, as well as decontamination of non-DEETZ locations contacted by the confirmed EVD patient will be undertaken according to the guidelines in (XIII) EVD Post Exposure Control Plan and Human Resources Considerations and (X) Environmental Infection Control for EVD.
13. HICS personnel will guide the process of decontamination and re-opening of all non-DEETZ locations.

d. Scenario #4: Unanticipated Identification of a Suspected EVD case at TRMC

In the event of the unanticipated arrival or identification of a Suspected EVD case (PUI) at TRMC the following actions will take place:

1. Upon notification or identification through risk assessment of the suspected EVD status of the patient and classification as a PUI, the patient will be isolated in place, behind a closed door as feasible, and all person traffic must be limited by security personnel. The Infection Preventionist and house supervisor must be notified immediately.
2. The HICS will be activated and roles assigned
3. The HERT will be notified and assembled in the Ambulance Bay
4. All other patients in Emergency Department 2 will be evacuated and all new patients diverted from the Emergency Department 2 to Emergency Department 1.
5. The DEETZ will be secured; all entrances and exits locked and supervised entry only by security personnel.
6. The DEETZ will be cleaned by Environmental Services as time permits.
7. All necessary supplies will be assembled and checked for functionality in the DEETZ.
8. Security will clear a path from the patients current location to the DEETZ. If the patient is already located in the DEETZ, no transport will be necessary.
9. The HERT will don appropriate PPE as set forth in the guidelines “Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)”, contact the confirmed EVD patient, and transport the patient to the DEETZ (if not already isolated there) according to guidelines set forth in (IX) Management of Suspected or Confirmed EVD Cases.
10. If Feasible, the HERT will contact the confirmed EVD patient and transport or escort the patient to the DEETZ according to guidelines set forth in (IX) Management of Suspected or Confirmed EVD Cases.
11. Contact tracing and investigation, as well as decontamination of non-DEETZ locations contacted by the suspected EVD patient will be undertaken according to the guidelines in (XIII) EVD Post Exposure Control Plan and Human Resources Considerations and (X) Environmental Infection Control for EVD.

12. HICS personnel will guide the process of decontamination and re-opening of all non-DEETZ locations.

Reference: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

Reference: http://www.cdc.gov/vhf/ebola/hcp/caring-for-ebola-suspects.html

VI. Notification of and Collaboration with Public Health Authorities and Healthcare Providers

The presence of one or more Suspected or Confirmed EVD cases at TRMC will result in the immediate notification of Tulare County Health and Human Services utilizing the below outlined procedure:

1. Upon identification of a PUI and appropriate activation of HICS, HERT and isolation protocols, The Incident Commander will designate a Liason Officer to immediately contact Tulare County Health and Human Services (TCHHS) Communicable Disease Control and Prevention at (559) 685-5720 or Emergency number: (559) 472-7092.
2. TCHHS will activate its Incident Command system and notify government authorities at CDPH and CDC, as well as coordinate its efforts through notification of its Public Health Emergency Preparedness (PHEP) authority.
3. If TCHHS is unable to be reached, CDPH may be reached at (855) 421-5921 or (510) 620-3424. CDPH will then relay information to CDC.
4. For specimen collection and referral for confirmatory testing of PUI cases, TCHHS microbiologists on call will work with TRMC HICS and HERT personnel to coordinate specimen collection, packaging and transport and can be reached at (559) 707-5683. For all other necessary procedures in specimen collection and transport, please refer to (VIII) Specimen Collection, Transport, Testing and Submission for Suspected EVD cases.
5. Upon confirmation of positive Ebola diagnosis for a patient currently isolated at TRMC DEETZ, CDC will coordinate with TRMC HICS and HERT the deployment of the 30 person Federal Ebola Rapid Response Team (FERRT) which will oversee clinical management, infection control and referral of confirmed EVD cases to a California Preferred Facility.

VII. Isolation and Infection Control of Suspected or Confirmed EVD Cases

Empiric isolation can be initiated by any clinical staff of any persons qualifying as PUI under EVD risk assessment guidelines outlined above. After notification of the Infection Preventionist, isolation and patient placement may be reassessed according to the above guidelines.

Isolation precautions for EVD will follow recommendations in the CDC document “Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Virus Disease in U.S. Hospitals” as well as those in policy #20-8003 Isolation Precautions for Infection Control.

Standard, Contact and Droplet precautions are recommended for management of hospitalized patients with known or suspected Ebola virus disease (EVD). Additional

infection control measures may be warranted if an EVD patient has other conditions or illnesses for which other measures are indicated and will follow those in policy #20-8003 Isolation Precautions for Infection Control. All guidelines on Personal Protective Equipment when directly caring for patients will follow those in the CDC document "Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)."

A. Key Components of Standard, Contact, and Droplet Precautions Recommended for Prevention of EVD Transmission in U.S. Hospitals:

Component	Recommendation
Patient Placement	1. Single patient room (containing a private bathroom) with the door closed 2. Facilities should maintain a log of all persons entering the patient's room
Personal Protective Equipment	Refer to "Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)." At a minimum, PPE should consist of: 1. N95 respirator or PAPR 2. Single-use (disposable) fluid-resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood. 3. Single-use (disposable) nitrile examination gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs. 4. Single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least mid-calf or single-use (disposable) shoe covers. 5. Single-use (disposable) fluid-resistant or impermeable shoe covers 6. Single-use (disposable), fluid-resistant or impermeable apron that covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea.
Patient Care Equipment	1. Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of patient care 2. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and hospital policy #20-8030 Cleaning and performing low Level Disinfection.
Patient Care Considerations	1. Limit the use of needles and other sharps as much as possible 2. Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care 3. All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed sharps containers.

Aerosol Generating Procedures	1. Avoid AGPs for patients with EVD. 2. If performing AGPs, use a combination of measures to reduce exposures from aerosol-generating procedures when performed on Ebola HF patients. 3. Visitors should not be present during aerosol-generating procedures. 4. Limiting the number of HCW present during the procedure to only those essential for patient-care and support. 5. Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room (AIIR) when feasible. Room doors should be kept closed during the procedure except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure. 6. HCW should wear appropriate PPE(http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html) during aerosol generating procedures. 7. Conduct environmental surface cleaning following prescribed procedures, utilizing FDA approved disinfectant with label claim for non-enveloped viruses.
Hand Hygiene	1. HCW should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. 2. Healthcare facilities should ensure that supplies for performing hand hygiene are available.
Safe Injection Practices	1. Facilities should follow safe injection practices as specified under Standard Precautions.
Duration of Infection Control Precautions	1. Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.

Additional Guidelines on Monitoring and management of potentially exposed personnel and environmental infection control can be found under (X) Environmental Infection Control for EVD and (XV) EVD Post Exposure Control Plan and Human Resources Considerations.

B. Personal Protective Equipment and Donning/Doffing Procedures for Treatment of Ebola Patients

Personal Protective Equipment for the prevention of transmission of EVD to HCW will follow most recent CDC guidelines as well as TRMC selection as to specific equipment, as well as donning/doffing procedures. All staff directly treating or otherwise caring for a confirmed or suspected Ebola patient shall don/doff appropriate PPE under the direction of a trained observer in a designated donning/doffing area with necessary equipment including, but not limited to Clean/Dirty:

1. Mats
2. Chairs
3. Tables
4. Hand hygiene product
5. A log of all entry/exit of personnel

TRMC specific donning/doffing procedures (Attachments F and G) including TRMC specific PPE selections shall be adhered to at all times. Any breaches in proper PPE donning/doffing procedures of breaches during patient care or evaluation must be reported immediately to the ERC and will be addressed according to guidelines in (XIV) EVD Post Exposure Control Plan and Human Resources Considerations.

Reference: http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html

Reference: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

Reference: http://www.cdc.gov/vhf/ebola/hcp/caring-for-ebola-suspects.html

VIII. Specimen Collection, Transport, Testing and Submission for Suspected EVD cases

A. Specimen Collection and Packaging

In coordination with TCHHS microbiologists, specimen collection, transport, testing and submission for suspected EVD cases will occur in accordance with guidelines in the CDC document “Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Persons Under Investigation for Ebola Virus Disease in the United States.”

All specimens will be collected by HERT personnel according to the above guidelines as well as those reflected in Attachment E and in the below procedure: in a clear, labeled, 4mL lavender top EDTA vial in the “hot zone” treatment room and placed in a durable, clear, leak proof primary container and the container or bag exterior disinfected before transport to the “warm zone” for secondary packaging. Secondary packaging will occur in conjunction with TCHHS for final transport.

1. HERT Nursing staff will collect blood samples for confirmatory lab testing according to needle safe guidelines and those reflected in .
2. Two vials of blood will be collected in clear, labeled, 4mL lavender top EDTA vials in the “hot zone” treatment room
3. Vials will be placed in a durable, clear, leak proof primary bag and the bag exterior disinfected with appropriate disinfecting product before transport to the “warm zone” for secondary packaging.
4. Package will then be handed, still wet with disinfecting product, to TCHHS microbiologists in the “warm zone” for arrangement of transport and secondary packaging.
5. Upon confirmation of positive Ebola diagnosis for a patient currently isolated at TRMC DEETZ, CDC will coordinate with TRMC HICS and HERT the deployment of the 30 person Federal Ebola Rapid Response Team (FERRT) which will oversee clinical management, infection control and referral of confirmed EVD cases to a California Preferred Facility.

B. Transport

Suspect EVD samples will be referred to Los Angeles Public Health Laboratory system for confirmatory testing, as coordinated by TCHHS and transported in compliance with 29 CFR 1910.1030 as a Class A specimen and Department of Transportation (DOT) Hazardous Materials Regulations. Additionally, because Ebola is an HHS Designated Select Agent, samples collected for confirmatory testing must also comply with HHS Select Agent regulations (42 CFR Part 73).

Reference: http://www.cdc.gov/vhf/ebola/hcp/select-agent-regulations.html

Reference:http://www.ecfr.gov/cgi-bin/text-idx?SID=2a97f2935677211e1785ac643163d2a9&node=49:2.1.1.3.10.5.25.33&rgn=div8

C. Testing and Submission

HICS personnel in conjunction with TCHHS will be responsible for coordinating and completing all required permits and paperwork for specimen transport and confirmatory testing in compliance with Federal and California regulations for Class A specimens.

The following procedure will be followed for submission of samples for EVD confirmatory testing in conjunction with and after notification of TCHHS:

- NO specimens will be accepted without prior consultation. For consultation call the CDC Emergency Operations Center at 770-488-7100.
- Contact your state and/or local health department and CDC to determine the proper category for shipment based on clinical history and risk assessment by CDC. State guidelines may differ and state or local health departments should be consulted prior to shipping.
- Email tracking number to EOCEVENT246@CDC.GOV.
- Do not ship for weekend delivery unless instructed by CDC.
- Ship to: Designated Los Angeles Public Health Laboratory Facility or:

  Centers for Disease Control and Prevention
  ATTN STAT LAB: VSPB, UNIT #70
  1600 Clifton Road NE
  Atlanta, GA 30333
  Phone 770-488-7100

- Include the following information: your name, the patient's name, test(s) requested, date of collection, laboratory or accession number, and the type of specimen being shipped.
- Include the CDC Infectious Disease (CDC Form 50.34) and Viral Special Pathogens Branch (referenced below) specimen submission forms, as well as any additional forms required by CDPH, TCHHS or transport or regulatory agency.
- On the outside of the box, specify how the specimen should be stored: refrigerated.

Any aspects of Specimen Collection, Transport, Testing and Submission for Suspected EVD cases not otherwise addressed above will follow CDC recommendations according to most current available interim guidance as referenced below.

Reference: http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

Reference: http://www.cdc.gov/vhf/ebola/pdf/ebola-lab-guidance.pdf

Reference: http://www.cdc.gov/ncezid/dhcpp/vspb/pdf/specimen-submission.pdf

Reference: http://www.cdc.gov/laboratory/specimen-submission/form.html

IX. Management of Suspected or Confirmed EVD Cases

A. Clinical Management and Treatment Recommendations

Clinical Management and Treatment for EVD focuses primarily on supportive therapy and treatment of complications as detailed above. Aggressive management of electrolyte abnormalities and rehydration have demonstrated success. Secondary infections can be treated with appropriate antimicrobials.

Reference: http://www.cdc.gov/vhf/ebola/treatment/index.html

Reference: http://www.cdc.gov/vhf/ebola/treatment/index.html

B. Performing Acute Hemodialysis

Acute renal failure requiring renal replacement therapy can occur in critically ill patients infected with Ebola virus. Because of necessary supportive therapy required in such cases, performing acute hemodialysis in patients with EVD should take place in accordance with CDC recommendations which include:

1. Patient placement in isolation room only
2. Vascular access by a highly trained HCW only
3. Minimization of blood exposure through local and multi organizational recommendations
4. Subclavian site avoidance
5. Ultrasound guidance
6. Needless connector device use
7. Use of dedicated equipment for the patient
8. Full, appropriate PPE use by HCW
9. Proper disposal of effluent
10. Proper equipment selection

Reference: http://www.cdc.gov/vhf/ebola/hcp/guidance-dialysis.html

C. Point of Care Laboratory Services

CDC has recommended point of care testing utilizing dedicated equipment for all Ebola treatment units currently assessing of treating a suspected or confirmed EVD patient. Because of the difficult nature of such testing, TRMC Clinical Lab has elected to provide the

following list of services (subject to change) on a point-of-care basis for an EVD patient currently isolated in the DEETZ:

1. Urine Dipstick
2. Hemoglobin
3. Heme Occult
4. Blood Glucose
5. Arterial Blood Gas

Any Clinical Lab personnel who are members of the HERT must don full appropriate PPE when performing such point of care testing according to guidelines above.

Reference: http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

D. Radiology Services

E. Caring for Pregnant Women with EVD

Reference: http://www.cdc.gov/vhf/ebola/hcp/guidance-maternal-health.html

F. Discharging Guidelines for PUI

Reference: http://www.cdc.gov/vhf/ebola/hcp/considerations-discharging-pui.html

G. Safely Handling Humans Remains of EVD patients

Reference: http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

X. Environmental Infection Control for EVD

XI. Referral and Transport of Suspected or Confirmed EVD cases

A. Preferred EVD Treatment Providers

CDPH has identified the University of California Health System (UCHS) as the preferred provider of EVD treatment in California and thus, if deemed medically and operationally prudent in collaboration with Public Health authorities, CDC and TRMC HICS will coordinate the referral and transport of any confirmed EVD case to the chosen UCHS facility at the earliest feasible opportunity in accordance with CDC guidelines “Guidance on Air Medical Transport for Patients with Ebola Virus Disease.”

Reference: http://www.cdph.ca.gov/Pages/NR14-088.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+CdphNewsRoom+(CDPH+News+Room)

Reference: http://www.cdc.gov/vhf/ebola/hcp/guidance-air-medical-transport-patients.html

B. Intra-Facility Transport of Suspected or Confirmed EVD cases

If intra-hospital transport of a suspected or confirmed EVD patient is deemed medically necessary for the performance of medical or surgical procedures unable to be performed in the DEETZ, the following guidelines will apply:

1. The clinical destination and path thereto of the patient will be cleared of all persons by security.
2. Housekeeping will clean the destination as time permits.
3. The patient will don PPE with assistance of the HERT staff including: N95 mask, surgical hood, boot covers and shoe covers, face shield and gloves.
4. The patient will be loaded onto a cleaned gurney draped with fluid impermeable sheets.
5. The patient will then be wrapped in fluid impermeable sheets so that no skin is exposed. Disposable restraints may be utilized to minimize shifting of the patient during transport.
6. HERT will then supervise the transport of the patient to the destination, performing frequent hand hygiene with alcohol based hand sanitizer and disinfectant wipes of equipment and personnel.
7. The patient will not remain outside the DEETZ longer than medically necessary and decontamination will take place according to established procedures in this policy.

C. Inter-Facility Transport of Suspected or Confirmed EVD cases

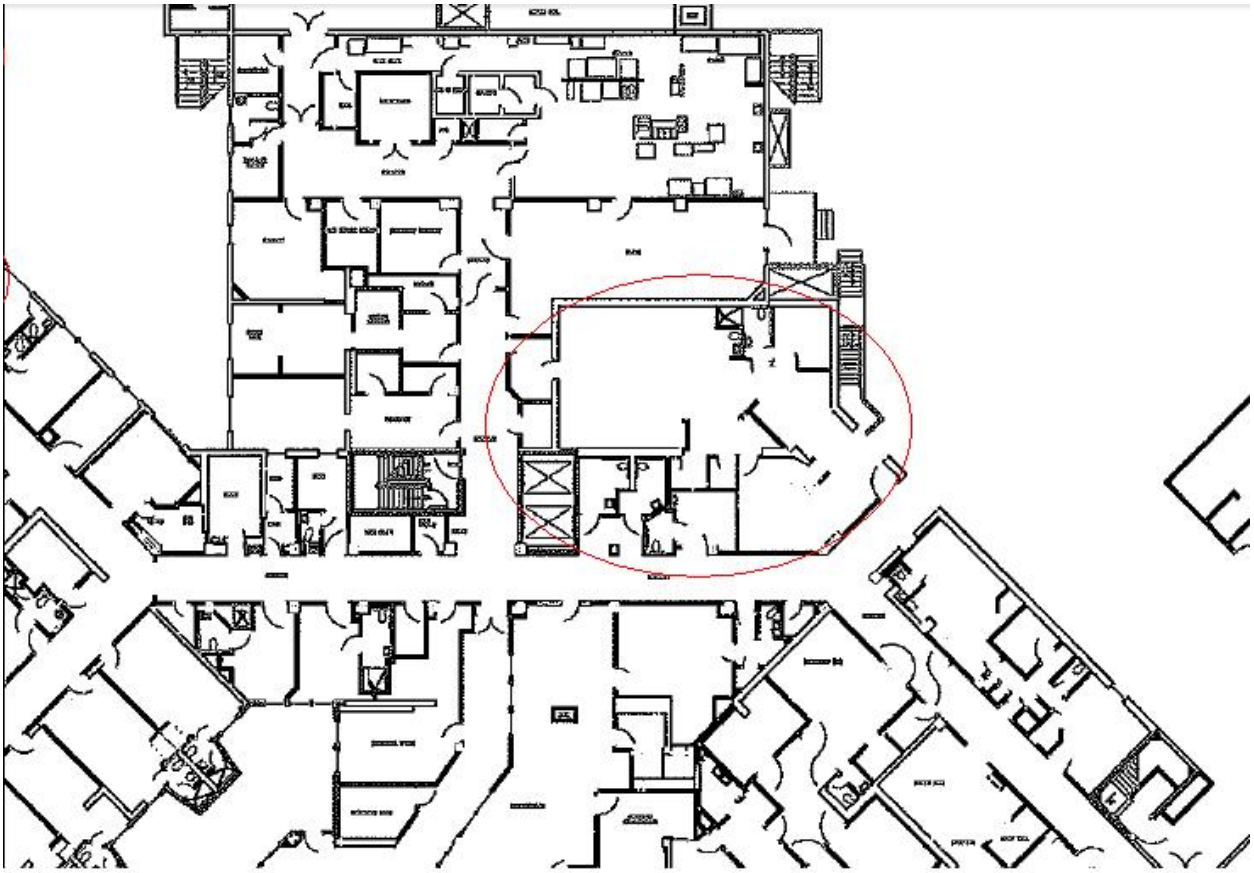
XII. Waste Management of Medical Waste of Suspected or Confirmed EVD Cases

XIII. Safe Handling of Human Remains of EVD Patients

XVI. **EVD Post Exposure Control Plan and Human Resources Considerations**

XIV. Staff Education and Training

Figure 1: TRMC Ebola Evaluation and Treatment Zone (DEETZ)



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

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

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

Upon arrival to clinical setting/triage

- ☐ Assess the patient for a fever (subjective or ≥ 100.4°F / 38.0°C)
- ☐ Determine if the patient has symptoms compatible EVD such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage
- ☐ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset

Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present

See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Upon initial assessment

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

Conduct a risk assessment for:

High-risk exposures

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

Low-risk exposures

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

Refer to Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing) (hyperlink: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

During aerosol-generating procedures

- ☐ Limit number of personnel present
- ☐ Conduct in an airborne infection isolation room
- ☐ Don PPE as described in the *Guidance on Personal Protective Equipment To Be Used by Healthcare Workers During Management of Patients with Ebola Virus Disease in U.S. Hospitals, Including Procedures for Putting On (Donning) and Removing (Doffing)* (hyperlink: http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)

Patient placement and care considerations

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

Initial patient management

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

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

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

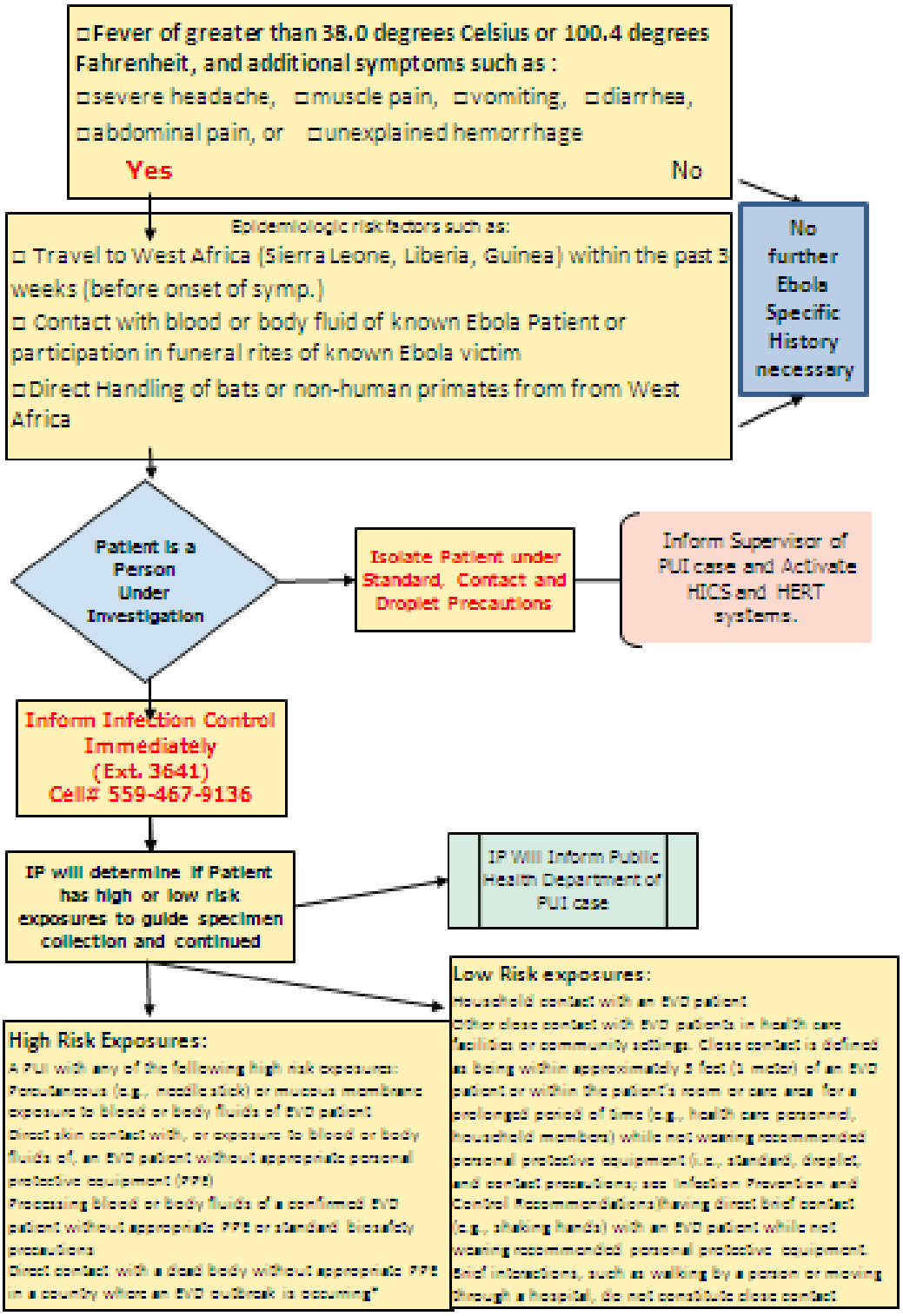
** See Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus at http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html

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

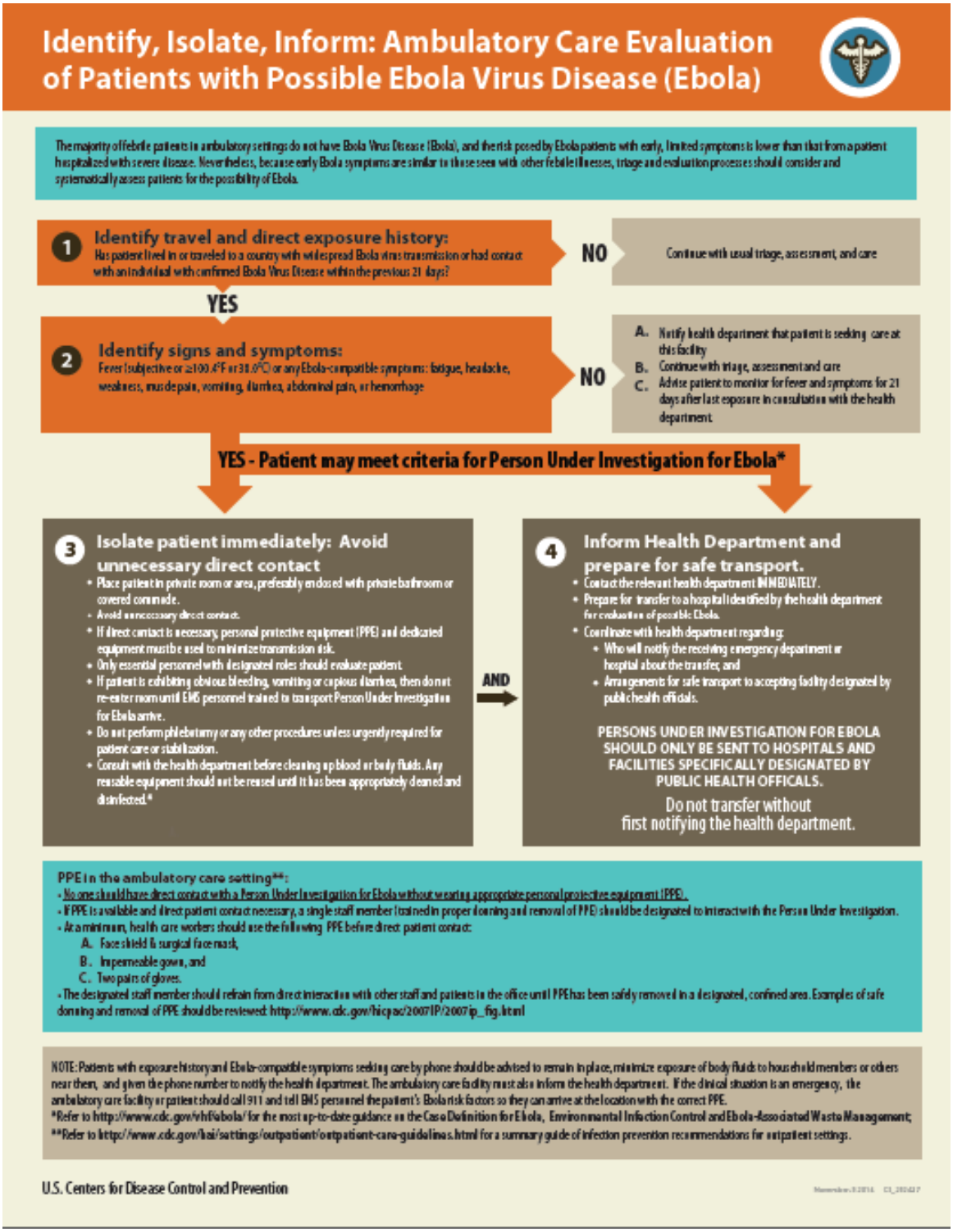
CS251924-B

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

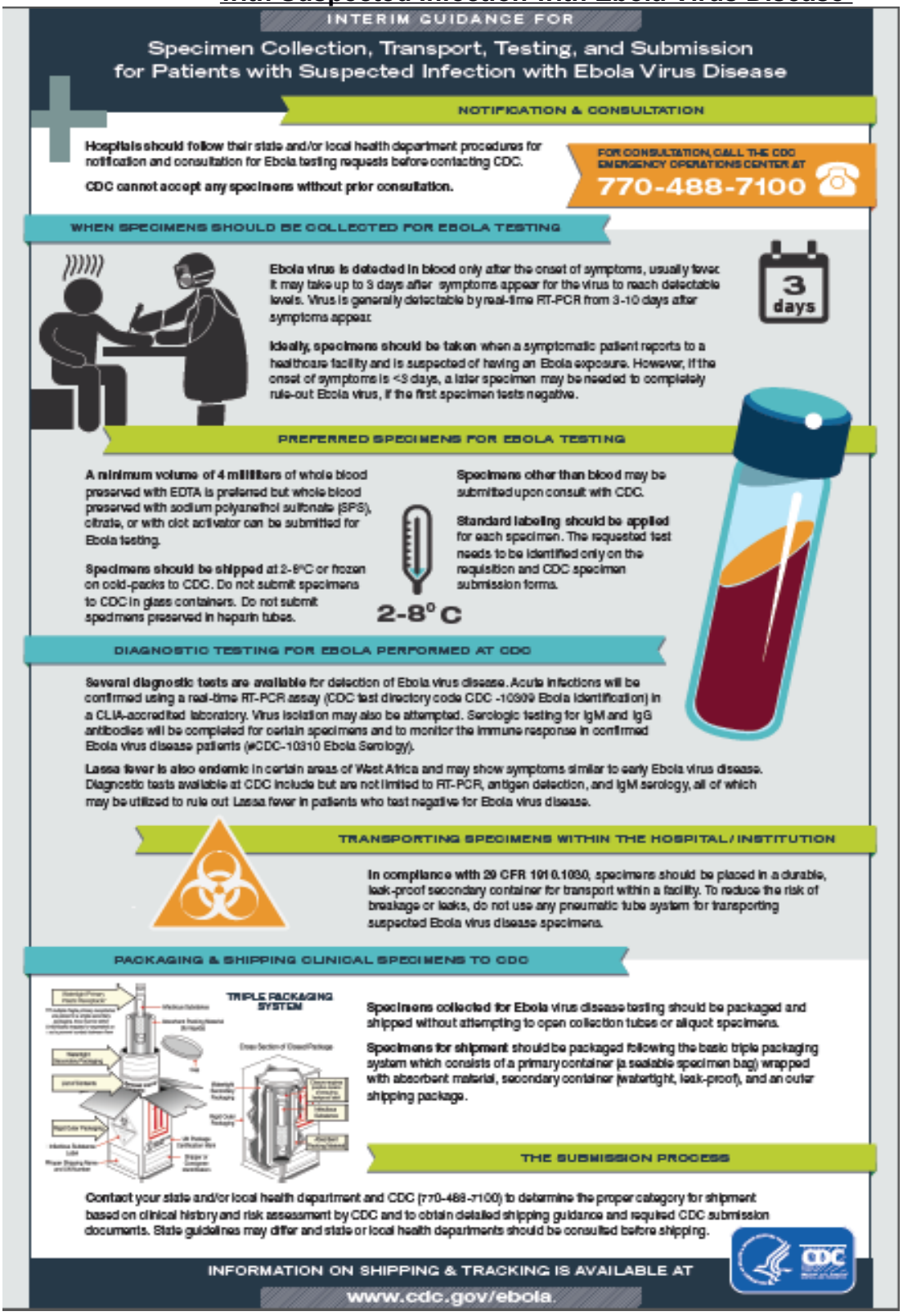
Attachment C: Ebola Risk Assessment Form



Attachment D: Identify, Isolate, Inform: Ambulatory care Evaluation of Patients with Possible Ebola Virus Disease (Ebola)



Attachment E: Specimen Collection, Transport, Testing, and Submission for Patients with Suspected Infection with Ebola Virus Disease



TULARE LOCAL HEALTHCARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY/GUIDELINE MANUAL
TULARE REGIONAL MEDICAL CENTER
Ebola Management: PPE Donning
Observer Checklist

Place Patient Sticker Here

Observer Name:_____
PPE Wearer Name: _____
Date:_____
Time PPE Donning Begun: _____ PPE Donning Complete:_____

INSTRUCTIONS: Read aloud each step in order after engaging the PPE wearer and initial when completed with disposable black pen.	**Completed Initials**	**Comments**
CRITERIA		
Engage Trained Observer: Visually Locates clean and dirty donning/doffing mats and chairs, and **engages trained observer.**		
Removes Personal Clothing and Items: Changes into surgical scrubs (or disposable garments) and dedicated washable (plastic or rubber) closed toe and closed heel footwear in a suitable clean area. No personal items (e.g., jewelry, watches, cell phones, pagers, pens) are kept on. Ensures hair is pulled back and nails are no more than ¼ inch.		
Inspects PPE Prior to Donning: Visually inspects the PPE ensemble to be worn to ensure that it is in good condition, that all required PPE and supplies are available, and that the sizes selected are correct for the healthcare worker. The trained observer reviews the donning sequence with the healthcare worker before the healthcare worker begins the donning process and reads it to the healthcare worker in a step-by-step fashion.		
Performs Hand Hygiene: Performs hand hygiene with ABHR. When using ABHR, allow hands to dry before moving to next step.		
Puts on Boot or shoe covers: Sits down to put on booties. Makes sure all areas of boots are covered. Tries not to touch floor or other areas with hands. If so, then ABHR is used. Makes sure booties are snug over ankle and calf.		
Puts on Inner Gloves: Put on first pair of gloves. Makes sure to pull cuffs as far up as possible.		
Puts on Coverall with Integrated Hood: Ensures coverall is large enough to allow unrestricted freedom of movement. If thumb hook are present, secures to inner gloves. Pulls up zipper or adhesive strip completely. Ensures cuffs of inner gloves are tucked under the sleeve of the coverall. If necessary, seals gap between inner gloves and coverall with medical tape, creating a tab for easy removal. **Does not** pull gown hood over head yet.		
Puts on N95 Respirator: Puts on correctly sized N95 respirator. Pulling both straps behind head, with one strap above and one strap below ear, not crossing straps. Molds nosepiece to nose, and completes a user seal check in the correct manner according to 3M user guidelines.		
Pulls coverall Hood over head: Pulls coverall hood over the N95 respirator, pulls the coverall surgical hood so that it covers all of the hair and the ears, and ensures that it is secured correctly with zipper or adhesive strip. Makes certain that hood completely covers the ears and neck.		
Puts on Outer Apron (if used): If Indicated by patient status or medical procedure puts on full-body apron to provide additional protection to the front of the body against exposure to body fluids or excrement from the patient.		
Puts on Outer Gloves: Puts on second pair of gloves (with extended cuffs). Ensures the cuffs are pulled over the sleeves of the coverall and secured with medical grade tape if necessary.		
Puts on Face Shield: Puts on full face shield over the N95 respirator and surgical hood. Bends forward slightly, takes thumbs inside elastic straps, places foam on forehead and pulls elastic band behind head. Checks that face shield provides complete protection to the front and sides of the face, including skin and eyes.		

Turn Over

Verifies: After completing the donning process, the integrity of the ensemble is		

TULARE REGIONAL MEDICAL CENTER

Ebola Management: PPE Doffing

Observer Checklist

Place Patient Sticker Here

Observer Name:_____

PPE Wearer Name: _____

Date:_____

Time PPE Doffing Begun: _____ PPE Doffing Complete:_____

INSTRUCTIONS: Read aloud each step in order after engaging the PPE wearer and initial when completed with disposable black pen.	**Completed Initials**	**Comments**
CRITERIA		
Prepares to Doff PPE: Gets the attention of the trained observer. Once clear signal is given, enters the doffing area. If any obvious material is adherent to the PPE, disinfectant wipes are used to correctly wipe the surface of the Healthcare workers PPE, and then a separate disinfectant wipe or ABHR is used to disinfect the outer gloves.		
Engages the trained observer and assistant (if present): correctly engages the trained observer and does not rush doffing process. Inspects PPE for any obvious tears, breaches or contaminants.		
Disinfects Outer Gloves: Disinfects outer-gloved hands with either an *EPA-registered disinfectant wipe or ABHR, and allows to dry		
Removes Apron (if used): Removes and discards apron taking care to avoid contaminating gloves by breaking strap and then rolling the apron from inside to outside.		
Inspects: Following apron removal, inspects the PPE ensemble to assess for visible contamination or cuts or tears. If visibly contaminated, then disinfects affected PPE using an *EPA-registered disinfectant wipe.		
Disinfect Outer Gloves: Disinfects outer-gloved hands with either an *EPA-registered disinfectant wipe or ABHR.		
Removes Outer Gloves: Does not snap gloves. Slowly holds one wrist and pinches glove, rolling down glove and balls up glove in one hand. Slides finger down and inside outer glove of other hand and rolls down correctly into one ball. Disposes properly.		
Inspects and Disinfects Inner Gloves: Inspects the inner gloves' outer surfaces for visible contamination, cuts, or tears. **If an inner glove is visibly soiled, cut, or torn**, then disinfects the glove with either an *EPA-registered disinfectant wipe or ABHR. Then removes the inner gloves, perform hand hygiene with ABHR on bare hands, and dons a clean pair of gloves. If no visible contamination, cuts, or tears are identified on the inner gloves, then disinfect the inner-gloved hands.		
Removes Face Shield: Removes the full face shield by tilting the head slightly forward, grabbing the rear strap and pulling it over the head, gently allowing the face shield to fall forward and discard. Avoids touching the front surface of the face shield.		
Disinfect Inner Gloves: Disinfect inner gloves with either an *EPA-registered disinfectant wipe or ABHR		
Pulls down Surgical Hood: Unfastens (if applicable) surgical hood, gently pulls down from back of head, making sure to roll hood so inside surface is covered. The trained observer may assist with rolling the hood correctly.		
Disinfect Inner Gloves: Disinfects inner gloves with either an *EPA-registered disinfectant wipe or ABHR.		
Removes Gown or Coverall: Removes coverall by tilting head back to reach zipper or fasteners. Unzips or unfastens coverall completely with one hand before rolling down and turning inside out with assistance of the assistant or observer. Avoids contact of scrubs with outer surface of coverall during removal. Touches only the inside of the coverall.		

Turn Over

Disinfects and Changes Inner Gloves: Disinfects inner gloves with either an *EPA-registered disinfectant wipe or ABHR. Removes and discards gloves taking care not to contaminate bare hands during removal process. Performs hand hygiene with ABHR. Dons a new pair of inner gloves.		
Removes Boot or Shoe Covers: While sitting down, removes and discards boot or shoe covers by grasping the outside of the boot cover and pulling it over the ankle, then the heel. Disposes correctly.		
Removes N95 Respirator: Removes the N95 respirator by tilting the head slightly forward, grasping first the bottom tie or elastic strap, then the top tie or elastic strap, and removes without touching the front of the N95 respirator. Discards N95 respirator		
Disinfects Inner Gloves: Disinfects inner gloves with either an *EPA-registered disinfectant wipe or ABHR		
Disinfects Washable Shoes: Sitting on a new clean surface (e.g., second clean chair, clean side of a bench) uses an *EPA-registered disinfectant wipe to wipe down every external surface of the washable shoes.		
Disinfects and Removes Inner Gloves: Disinfects inner-gloved hands with either an *EPA-registered disinfectant wipe or ABHR. Removes and discards gloves taking care not to contaminate bare hands during removal process.		
Performs Hand Hygiene: Perform hand hygiene with ABHR.		
Reviews for Body Contaminants: Performs a final inspection of healthcare worker for any indication of contamination of the surgical scrubs or disposable garments. If contamination is identified, immediately informs infection Preventionist or occupational safety and health coordinator or their designees before exiting PPE removal area.		
Exits Doffing Area keeping on Scrubs: Healthcare worker leaves PPE removal area wearing dedicated washable footwear and surgical scrubs or disposable garments.		
Showers: Showers are recommended at each shift's end for healthcare workers performing high risk patient care (e.g., exposed to large quantities of blood, body fluids, or excreta). Showers are also suggested for healthcare workers spending extended periods of time in the Ebola patient room. If appropriate, reports to designated Ebola Care team shower		
Protocol Evaluation/Medical Assessment: Either the infection preventionist or occupational health safety and health coordinator or their designee on the unit at the time are informed to meet with the healthcare worker to review the patient care activities performed to identify any concerns about care protocols and to record healthcare worker's level of fatigue.		

Descriptive Name: Identification and Triage, Testing, Management and Infection Control of Suspected and Confirmed Cases of Ebola Virus Disease (EVD)

Descriptive Type: New Policy

Document Number: 20-8040

Attachments: Yes

Author: Jonathan Schouest /Josh Warren

Typist: Maritza Sevilano

Creation Date: 10/12/2014

Revision Date: 4/16/18

Prev. Dist. Date: 10/1/15

Committee Review and Approval:	Approval Date:	Comments:
Infection Prevention Committee	N/A	Date change only
MEC	N/A	Date change only
Board of Directors		

Effective Date:

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Departments

FROM: Administration

SUBJECT: Code Yellow - Bomb Threat (Disaster)

I. PURPOSE

To establish a method for coordinating an appropriate facility response that ensures immediate protection of life, property and the continuation of vital patient care services in the event of a bomb threat or discovery of a suspicious package.

II. SUPPORTING INFORMATION

Bomb threats do occur in healthcare facilities. A facility will make an initial search when a credible bomb threat is received. The facility may choose not to evacuate unless a suspicious device has been identified, and then proceed under the direction of the local authority. Safety procedures take precedence over all other activities by healthcare facility employees, except for the provision of immediate medical assistance to patients in life-threatening circumstances.

III. DUTIES AND RESPONSIBILITIES

A. NURSING SUPERVISOR/DESIGNEE

1. When notification of the threat is received, the threat shall be reported immediately to the Nursing Supervisor or designee. No one else should be told of the threat unless advised to do so by the Nursing Supervisor or designee.

2. The Nursing Supervisor/designee or PBX shall contact the Fire and Police Department, Administrator and the Chief Clinical Officer if not already notified.

3. A command post for any search effort shall be established. The Nursing Supervisor/designee shall assume overall responsibility for a search until which time the Police and/or Fire Department takes over.

Upon direction from the Nursing Supervisor and/or Administration, a "Code Yellow" may be announced.

4. Upon arrival, the Police and or Fire Department will assist Hospital Security in a search of the grounds and public areas. The Police Department will assume command should a bomb or suspected bomb be found.

B. COMMUNICATIONS

The following is a list of questions to ask a caller in an event of a Bomb Threat.

BOMB THREAT TELEPHONE CHECKLIST

1. **Instructions:** *Be calm. Be courteous. Listen.*
   a. Do not interrupt the caller.
   b. Notify your supervisor or someone in your area when the caller is on the line if possible.

2. Most bomb threat calls are very brief. The caller normally states his/her message and hangs up. However, every effort should be made to obtain as much detailed information as possible from the caller.

3. Date of Call: _____ Time of Call: _____ am/pm

4. Ask the following questions:

   a. What is the exact location of the bomb?

   b. What time is it set to go off?

   c. What does the bomb look like?

   d. What is it made of?

   e. What will make the bomb explode?

   f. How can the bomb be deactivated?

   g. Why was it placed?

If the caller is reluctant to answer the above questions, they should be told that the facility cannot be vacated in the warning

time, and that their failure to provide answers could result in the death or serious injury to many innocent people.

To the best of your ability, record the exact words of the caller and answer the following:

Caller's identity: _____

Sex: Male ___ Female ___Adult ___Juvenile __Approximate Age __

Origin of Call: _____ Local _____ Long Distance

Callers Voice: (describe) _____

Speech:fast ___ slow ___ nasal ___ stutter ___ distinct ___
slurred ___ distorted ___ muffled ___ lisp ___

Voice: raspy ___ high pitched ___ pleasant ___ deep ___
intoxicated ___

Language:clear ___ garbled ___ foul ___ other _____

Accent:local ___ racial ___ regional ___ foreign ___

Manner: calm ___ angry ___ serious ___ tense ___ sure ___
unsure ___ joking ___ rational ___ irrational ___
laughing ___ emotional ___ righteous ___ deliberate ___
nervous ___ coherent ___ incoherent ___ other _____

Background noise: (describe) _____

voices ___ music ___ trains ___ office machines ___
factory machines ____ street traffic ___ animals ___
airplanes ___ party atmosphere ___ quiet ___

Phone connection: (describe) _____

clear ___ pay phone ___ cellular phone ___ static ___
long distance ___ other _____

Remarks: _____
_____
_____

C. OTHER UNITS:

1. Once a search order has been issued by the Incident Commander, the following procedure shall be followed:

   a. The handling of bombs and bombing investigations is solely an official police function. At no time should the hospital security staff try to touch a bomb or suspected bomb. The role of the facility security staff is to help the police find the bomb, and to evacuate patients, visitors and facility personnel.

   b. When the police enter the healthcare facility they will need trained personnel who are familiar with the facility to assist them in searching for a possible bomb. Security personnel should be completely familiar with all areas of the building, including closets, restrooms, storage areas, trash bins, etc. All security officers should have keys to these areas so that a complete search can be made.

   c. Individuals searching specific areas shall report an AREA CLEAR to the Command Post as soon as possible

2. Should a suspect package or bomb be found, Incident Commander is to be notified immediately.

   a. The suspect package is **NOT TO BE**

      1. Touched
      2. Moved
      3. Tilted
      4. Lifted
      5. Unwrapped
      6. Or otherwise disturbed

   b. The Incident Commander and/or administrator will confer with Police on the scene and decide whether or not to activate the evacuation plan. Final decision to evacuate shall be made by the Nursing Supervisor/designee or Administration.

c. If a bomb activates, or if other signs are indicated, Incident Commander shall notify PBX to announce a "Code Triage Internal" initiating an "internal disaster," major, moderate or minor however, at ~~no time~~NO TIME shall the operator announce that there is a bomb threat.

D. GENERAL PROCEDURES AND INFORMATION

1. Bomb threats shall not be discussed with patients or visitors.

2. All search efforts shall be handled discreetly.

3. All newspaper or other media inquiries should be directed to the Public Information Officer (PIO) or designee who will report to Administration to determine the extent of public relations involvement needed. If necessary, the PIO or designee will then coordinate the media command center in the designated area and assign personnel to designated tasks and stations.

4. A bomb will probably be packaged inconspicuously and will appear as something you see every day.

   a. Neatly wrapped package (may have a message written on outside).

   b. Briefcase, suitcase, toolbox.

   c. Book (hollowed out).

   d. Piece of pipe with a fuse protruding.

   e. Round sticks taped together with a fuse.

   f. Anything new or added to any area is to be considered suspect.

5. Until a determination as to the validity of the bomb has been made it will be treated as a real bomb.

6. Once it is determined that no bomb exists or if one was found and removed, and if a "Code Yellow" was announced, the Nursing Supervisor and/or Administration will advise PBX to announce an "all clear".

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guidelines replaces and supersedes all previous policy/guidelines concerning this matter and is effective immediately.

Descriptive Name: Bomb Threat – Code Yellow (Disaster)

Descriptive Type: Revised

Document Number: 21-2005

Attachments: None

Author: Lionel Machado

Typist: ~~Melissa Arend~~

Revision Date: ~~07/01/14~~

Prev. Dist. Date: 07/28/11

Committee Review and Approval:	Approval Date:	Comments:
Emergency Management Comm.	~~07/22/14~~	
EOC Committee	~~07/24/14~~	
MEC	~~09/09/15~~	
Board of Directors	~~09/30/15~~	

Effective Date: ~~10/1/15~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba Tulare Regional Medical Center
POLICY / GUIDELINE

TO: All Employees

FROM: Administration

SUBJECT: Communications Plan during Disaster or Communications Failure

I. Policy:

In the event of a failure or disruption of the Hospital or local communications systems, the following plan will be implemented:

A. For intra-Hospital communications, the Hospital owned two-way radio system will be used for communications between departments, Administration, security staff, etc. The radios will be maintained and safeguarded per Hospital Policy #14-3013, "Safeguarding Two-Way Radios." Radios will be assigned to staff/ departments per the Hospital Disaster Plan, or at the direction of Administration and/or the Hospital Supervisor.

B. Cell phones may also be used in the event of failure or disruption to the Hospital communication system, if needed. A log will be maintained in each department of any cell phones used by Hospital Staff for Hospital business, and related expenses will be reimbursed by the hospital (see attached).

C. In the case of a major disaster, when normal calling methods are unsuccessful, Administration will institute the use of GETS (Governmental Emergency Telecommunications Service), which will allow phone communications to be obtained. The GETS cards are distributed as follows: CEO, CCO, CFO/COO, Chief of Quality / Compliance Officer, Safety Officer, Director of Communications, EMC Coordinator.

D. GETS cards will only be used in the case of emergency situations, where phone communication is impaired and lines are unobtainable.

E. GETS procedure is as follows:

1. User will call a universal number (1-710-NCS-GETS).

2. Prompts will direct you to enter 12-digit card number and destination phone number.

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

EMERGENCY COMMUNICATIONS RECORD

In the event of a hospital or local communications failure, available hospital, employee and/or physician cellular phones may be used for communications inside the Hospital facility.

Complete the information below to document individual cell phone use during the communications failure. To receive reimbursement, submit a copy of the cellular service invoice reflecting call times used during the communications failure to administration within 30 days.

Dept.	**~~Manager~~Director:**	**Ext.**

Communications Failure Started:	**Date:**	**Time:**
Communications Failure Ended:	**Date:**	**Time:**

Name of Owner:	**Cellular Phone #**	**Cellular Service**

Descriptive Name: Communications Plan during Disaster or Communications Failure

Descriptive Type: Revised

Document Number: 21-2021

Attachments: Attached

Author: ~~Teri Alameda (Health and Safety Consultants)~~ Lionel Machado

Typist: ~~Jennifer Bridges~~

Creation Date: 07/18/13

Previous Dist. Date: 10/21/10

Committee Review:	Approval Date:	Comments:
Emergency Management Committee	~~09/17/13~~ 07-25-17	
Safety (Environment of Care) Committee	~~09/19/13~~ 07-27-17	
Medical Executive Committee	~~01/15/14~~	
Board of Directors	~~01/22/14~~	

Effective Date: ~~01/23/14~~

Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba Tulare Regional Medical Center
POLICY / GUIDELINE

TO: All Employees

FROM: Administration

SUBJECT: Water Management Plan

I. Purpose:

The purpose is to provide guidelines for accessing Tulare Regional Medical Center water resources in times of crisis. In addition, this program is in place to ensure patient safety, sustain care, treatment, and services.

II. Scope:

A. This plan applies to Tulare Regional Medical Center

B. This plan is intended to be used in conjunction with the ***Loss of Water Response and Recovery Guidelines (Appendix A)***

C. The interruption of the domestic water supply affects the operation of the following physical plant services:

1. Heating and air conditioning
2. Compressed air
3. Steam and sterilization
4. Domestic hot and cold water systems
5. Sanitary sewage systems
6. Film processing
7. Fire protection water
8. Ice makers
9. De-ionized water

10. Kitchen dishwashing equipment and food preparation.

11. Information Systems cooling systems

III. Purifying water in an emergency:

A. Water Purity: The Center for Disease Control and the American Red Cross recommend these steps to disinfect drinking water in an emergency:

1. Boil Method (preferred method): Filter the water through coffee filters or a clean cloth to remove any sediment.

a. Bring water to a rapid boil for 3 minutes.

b. To improve the flat taste of boiled water, aerate it by pouring it back and forth from one container to another and allow it to stand for a few hours.

OR

2. Chlorine Method: Filter the water through coffee filters or a clean cloth to remove any sediment.

a. Use non-scented, household chlorine bleach that contains a chlorine compound to disinfect water. Do **not** use non-chlorine bleach to disinfect water.

b. Follow the procedure written on the label. When the necessary procedure is not provided, locate the percentage of available chlorine on the label and use the information in the following table as a guide (1/8 teaspoon and 8 drops are approximately the same quantity).

Available Chlorine	**Drops per Quart/Gallon of Clear Water***	**Drops per Liter of Clear Water**
1 %	10 per Quart – 40 per Gallon	10 per Liter
4 – 6 %	2 per Quart – 8 per Gallon (1/8 teaspoon)	2 per Liter
7 – 10 %	1 per Quart – 4 per Gallon	1 per Liter
Unknown	10 per Quart – 40 per Gallon	10 per Liter

***** Double the amount of chlorine for cloudy, murky or colored water or water that is extremely cold.

c. Mix the treated water thoroughly and allow it to stand, preferably covered, for 30 minutes.

d. The water should have a slight chlorine odor. If not, repeat the dosage and allow the water to stand for an additional 15 minutes. If the treated water has too strong a chlorine taste, allow the water to stand exposed to the air for a few hours or pour it from one clean container to another, several times.

IV. Regulatory Requirements:

A. Water Temperature (California):

1. Patient Care unit domestic hot water: Temperatures are not to exceed 120 degrees Fahrenheit. In the event that patient care area water temperature limits are exceeded, the following will occur:

   a. Notification to patient care areas of the temporary shut down.

   b. Hot water will be shut off.

   c. Temperature will be adjusted and verified that temperature is within limits.

   d. Restore hot water supply to patient care units and inform staff that they may resume hot water use.

2. Dishwashing hot water: The utensils shall be thoroughly washed in hot water with a minimum temperature of ~~150~~ 110 degrees Fahrenheit and temperature at a minimum of 180 degrees Fahrenheit for final rinse.

   a. Faucets in the facility that deliver water at or higher than 125 degrees Fahrenheit are labeled with warning signs with letters of at least two inches high.

V. Mitigation:

The following mitigation processes are in place:

A. To prevent cross-contamination of potable water with wastewater, lines are equipped with back-flow valves, as needed. Engineering ensures annual testing of these back-flow valves and maintains test result documentation.

B. Alternate Water Sources are in place in the event that there is a water system failure to sustain services for 96 hours:

1. Potable (drinkable): The minimum requirement for drinking water should be, at least, 1 gallon per person, per day.

   a. Bottled drinking water is located in the food service storage room._

   b. If additional drinking water is needed until normal service can be restored, Tulare Regional Medical Center has arranged with vendor(s) to provide bulk water deliveries, as needed. See available vendors listed on the Hospital Resource Directory (HICS Form 258).

      (i) Well water will be used for domestic water.

      (ii) The organization recognized the risk that some vendors may not be available to supply needed water when multiple organizations are competing for a limited supply from the same vendor, therefore, vendors located remotely are included in the contingency plan.

      (iii) The water vendors will provide water-containing bladders holding, approximately, 1500 gallons to be staged outside the facility to supply water for gross contamination of equipment, as well as for the "bucket brigade," to flush toilets.

2. The Hospital has a potable water supply from the well located on the south west corner of campus. This water is tested annually and has been deemed consumable. This water can be dispensed from existing faucets throughout the facility.

3. Non-potable water: The well water supply can be utilized. This water source can be dispensed from a submersible pump and back up electrical sources, which are stored with the disaster supplies. Other non-potable water sources include: Medical air compressors water reclamation system and the main city water irrigation system.

4. Sterile Water: The existing supplies of prepackaged water for sterile water and sterile saline will be utilized for cleansing wounds and irrigation, preparing laboratory controls and preparing baby/infant formulas.

5. Coordination of the healthcare resources and assets, during an event, is an Operation area ~~(OES~~Office of Emergency Services~~)~~ function and responsibility, and will be under the

jurisdiction of Tulare County OES. Periodic joint meetings, involving the local utility company, water bureau, public health department, hospitals, fire department, police, and emergency medical services ensure resources (e.g., water) are evaluated and planned.

6. In the event 96 hours of water is not available at the time of true need and the facility is unable to obtain additional supplies, a decision will be made 24 hours prior to exhaustion of water resources by the Command Team to stage an evacuation to ensure patient care is not compromised.

VI. Preparedness:

The following preparedness programs are in place:

A. The Emergency Management Procedures

B. Testing and maintenance of utility systems.

C. Education and training of staff.

D. Exercises to test the effectiveness of the response to the Emergency Operation Plan.

VII. Response:

A. Staff that discovers the water disruption notifies Engineering to evaluate the problem.

1. Engineering personnel will contact the Administrator on call.

2. Incident Commander will open the Hospital Command Center and follow the ***Loss of Water Incident Response & Recovery Guidelines (Appendix A,)***.

VIII. References and Applicable Regulatory Standards:

Center for Disease Recommendations for Disinfecting Water in an Emergency
Accrediting Agencies
CA Licensing and Certification of Health Care Facilities:
Title 22, 70273, Dietetic Service General Requirements
Title 22, 70741, Disaster and Mass Casualty
Title 22, 70863, Water Supply and Plumbing
Hospital Incident Command System

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

Mission: To effectively and efficiently manage the effects of a loss of water in the facility.

Directions:

☐ Read this entire response guide and review incident management team chart.

☐ Use this response guide as a checklist to ensure all tasks are addressed and completed.

Objectives:

☐ Conserve water and restore water supply.

☐ Identify and obtain alternate sources of potable water.

☐ Maintain patient care management.

☐ Monitor heating and cooling systems.

Immediate (Operational Period 0 – 2 Hours):

COMMAND

(Incident Commander):

☐ Activate the facility Emergency Operations Plan.
☐ Activate appropriate Command Staff and Section Chiefs.
☐ Activate Infection Control as a Medical/Technical Specialist.
☐ Establish incident objectives and operation period.

(Public Information Officer):

☐ Inform staff, patients and families of situation and measures to conserve water and protect life. If possible, inform patients through briefings, letters on meal trays with updates on the process.
☐ Remind staff to contact ~~eh~~ the PIO if the media presents. Staff is not to provide comments to the media.
☐ Prepare a media staging area.
☐ Conduct regular media briefings, in collaboration with the local emergency management, as appropriate.

(Liaison Officer):

☐ Notify the Office of Emergency Services of the situation and immediate actions. Notify the Health Department.
☐ Alert the Fire Department of Hospital situation status, critical issues and timeline for water service repairs and restoration
☐ Notify the water utility and outside agencies of water loss and estimated time for the water main repair and restoration of service.
☐ Notify local EMS and ambulance providers about the situation and possible need to evacuate.
☐ Communicate with other healthcare facilities to determine:
  ☐ Situation status.
  ☐ Surge capacity.
  ☐ Patient transfer/bed availability.
  ☐ Ability to loan needed equipment, supplies, medications, personnel, etc.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

(Safety Officer):

☐ Evaluate the safety of patients, family, staff and facility and recommend protective and corrective actions to minimize hazards and risks.
☐ Ensure staff is utilizing appropriate personal protective equipment and have the required training.

(Medical/Technical Specialist) Infection Control:

☐ Ensure personal hygiene and sanitation needs of patients, staff and visitors are addressed based on risk and availability of supplies (e.g., antimicrobial soap and water, alcohol-based products).

OPERATIONS:

☐ Determine the loss of water impact on systems and patients.
☐ Shut off, limit and/or monitor all non-essential water usage (e.g., ice machines, garden sprinklers). If necessary, shut down air conditioner drinking fountains and close down select toilets. Attach the appropriate signage.
☐ Evaluate if boiler pressure needs to be reduced, osmosis system and solution makers (water distillers and deionizers).
☐ Estimate potable and non-potable water usage and needs and collaborate with the Logistics Section and the Liaison Officer to obtain back-up supplies.
☐ Institute alternative waste disposal methods and notify staff of the method. Patient toilets are to be lined, prior to use, with plastic trash bags in the toilet bowl. Once the waste is in the bag, double tie the plastic bags and place the bag into a red bag and double tie that bag to minimize the potential for fluid spillage or leakage. Handle these bags with universal precautions for contaminated/infectious waste. Place in the biohazardous waste barrels with tight fitting lids for storage OR staff use buckets to "flush" waste down the toilet. Bedside Commodes and Bedpans: Line with red bags or chux prior to use and dispose of as medical waste.
☐ Access alternate sources of water to provide for fire suppression, HVAC system and other critical systems, as able.
☐ Institute rationing of water, as appropriate.
☐ Institute Fire Watch in the facility if the fire system is compromised. Document on Fire Watch log.
☐ Initiate water conservation measures.
☐ Post signs at the major entrances communicating to the public about the utility failure.
☐ Assess patients for risk and prioritize care and resources, as appropriate. Limit patient baths to those medially necessary (consider use of sponge baths).
☐ Monitor infection control practices.
☐ Use disposable surgical instruments whenever possible. Utilize the Infection Control policy for instrument sterilization in a disaster (no power or water).
☐ Provide alternate toilet and hand washing facilities. Portable restrooms and washing facilities will be stationed outside of the facility.
☐ Secure the facility and implement limited visitation policy. Security will assist in controlling access to stored water.
☐ Ensure continuation of patient care and essential services.
☐ Consider partial or complete evacuation of the facility, or relocation of patients and services within the facility.
☐ Activate facility and impacted departmental business continuity plans.
☐ In the event water needs to be purified, strain the water through coffee filters or a clean cloth to remove any sediment. Bring water to a rapid boil for 5 to 10 minutes.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

PLANNING:

☐ Establish operational periods, incident objective and develop the Incident Action Plan, in collaboration with the Incident Commander.
☐ Prepare for patient and personnel tracking in the event of evacuations.
☐ Consider increasing staffing.

LOGISTICS:

☐ Maintain other utilities and activate alternate systems, as needed.
☐ Investigate and provide recommendations for alternate water supplies, including potable water and hand washing facilities.
☐ Notify water and ice suppliers to make a delivery.
☐ Procure portable water heaters, if needed. Microwaves can be utilized to warm water.
☐ Ensure waterless hand cleaner is distributed, with the help of the Labor Pool.
☐ Ensure sterile processing has buckets of water for gross decontamination of equipment, prior to transport of equipment to other hospitals for emergency sterilization.
☐ Assist with rationing water, as appropriate.
☐ Obtain supplemental staffing, as needed.
☐ Prepare for transportation of evacuated patients, if activated.
☐ Oversee and conduct water main repairs and restoration of services.

Intermediate and Extended (Operational Period 2 – Greater than 12 Hours):

COMMAND

(Incident Commander):

☐ Update and revise the Incident Action Plan and prepare for demobilization.
☐ Continue to update internal officials on the situation status.
☐ Monitor evacuation, if activated.

(Public Information Officer):

☐ Continue with briefings and situation updates with staff, patients and families.
☐ Request staff to turn faucets to “off” position, in case of unexpected or partial return of water pressure.
☐ Continue patient information center operations, in collaboration with Liaison Officer.
☐ Assist with notification of patient’s families about the situation and evacuation, if activated.

(Liaison Officer):

☐ Continue to notify County EOC of situation status, critical issues and request assistance, as needed.
☐ Continue to communicate with local utilities about incident details and duration estimates.
☐ Continue patient information center operations, in collaboration with PIO.
☐ Continue communications with area hospitals and facilitate patient transfers.

(Safety Officer):

☐ Continue to evaluate facility operations for safety and hazards and take immediate corrective actions.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

OPERATIONS:

☐ Continue evaluation of patients and patient care.
☐ Cancel elective surgeries and procedures.
☐ If appropriate, prepare the staging area for patient transfer/evacuation.
☐ Initiate ambulance diversions procedures.
☐ Continue or implement patient evacuation.
☐ Ensure the transfer of patient's belongings, medications and records, upon evacuation.
☐ Continue to ration water, especially potable water, as appropriate.
☐ Maintain facility security and restricted visitation.
☐ Continue to maintain other utilities.
☐ Monitor patients for adverse affects of health and psychological stress.

PLANNING:

☐ Continue patient, bed and personnel tracking.
☐ Update and revise the Incident Action Plan.
☐ Prepare the demobilization and system recovery plans.
☐ Plan for repatriation of patients.
☐ Ensure documentation of actions, decisions and activities including photo documentation of the site/affected area.

LOGISTICS:

☐ Continue with nutritional, sanitation, and HVAC support and operation.
☐ Contact vendors to provide emergency potable and non-potable water supplies and portable toilets with hand washing sinks.
☐ Monitor the impact of the loss of water on critical areas.
☐ Continue to provide staff for patient care and evacuation.
☐ Monitor staff for adverse affects of health and psychological stress.
☐ Monitor, report, follow-up and document staff or patient injuries.
☐ Continue to provide to provide transportation services for internal operations and patient evacuation.

FINANCE/ADMINISTRATION:

☐ Continue to track costs, expenditures and lost revenue.
☐ Continue to facilitate contracting for back-up medical gas/vacuum and other services.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

Demobilization/System Recovery:

COMMAND

(Incident Commander):

☐ Determine hospital status and declare restoration of normal supply of medical gas and vacuum and termination of the incident.
☐ Notify state licensing, accreditation or regulatory agency of sentinel event.
☐ Provide appreciation and recognition to solicited and non-solicited volunteers and to state and federal personnel sent to help.

(Public Information Officer):

☐ Conduct the final media briefing and assist with updating staff, patients, families and others of the termination of the event.

(Liaison Officer):

☐ Communicate final hospital status and termination of the incident to local EOC, area hospitals and officials.
☐ Assist with the repatriation of patients transferred.

(Safety Officer):

☐ Ensure facility safety and restoration of normal operations.

OPERATIONS:

☐ Confirm water restoration plan with local water authority and complete bacteriological testing and final potable water safety verification.
☐ Restore normal patient care operations.
☐ Ensure restoration of water and other infrastructure (i.e., HVAC). Water will need to be re-energized into the facility slowly, therefore, draining and flushing of lines will be coordinated.
☐ Repatriate evacuated patients.
☐ Discontinue ambulance diversion and visitor limitations.
☐ Notification to staff when water system is functioning by paging announcement to resume duties.

PLANNING:

☐ Finalize the Incident Action Plan and demobilization plan.
☐ Compile a final report of the incident and hospital response and recovery operations.
☐ Ensure appropriate archiving of incident documentation.
☐ Conduct after-action reviews and de-briefing.
☐ Write an after-action report and corrective action plan for approval by the Incident Commander to include the following:
  - ☐ Summary of actions taken.
  - ☐ Summary of the incident.
  - ☐ Actions that went well.
  - ☐ Area for improvement.

☐ Recommendations for future response actions.

Appendix A: Water Management Plan Incident Response and Recovery Guideline

LOGISTICS:

☐ Perform evaluation and preventative maintenance on medical gas and vacuum equipment by a certified contractor.
☐ Re-stock supplies, equipment, medications, food and water.
☐ Ensure communications and IT/IS operations return to normal.
☐ Conduct stress management, after-action debriefings and meetings, as necessary.

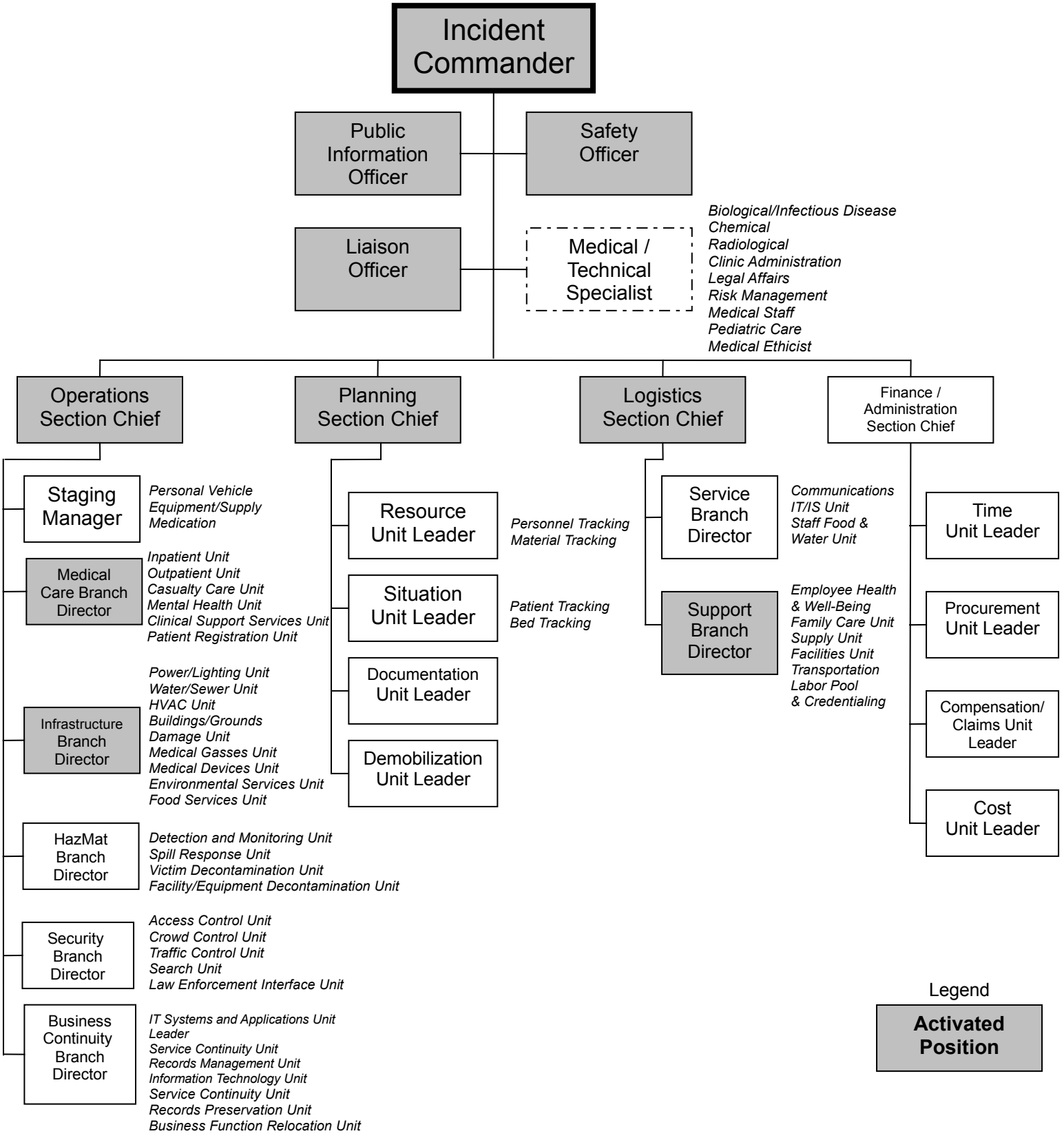
FINANCE/ADMINISTRATION:

☐ Compile a final report of response costs and expenditures and lost revenue for approval by the Incident Commander.
☐ Contact the insurance carriers to assist in documentation of structural and infrastructure damage and initiate reimbursement and claims procedures.

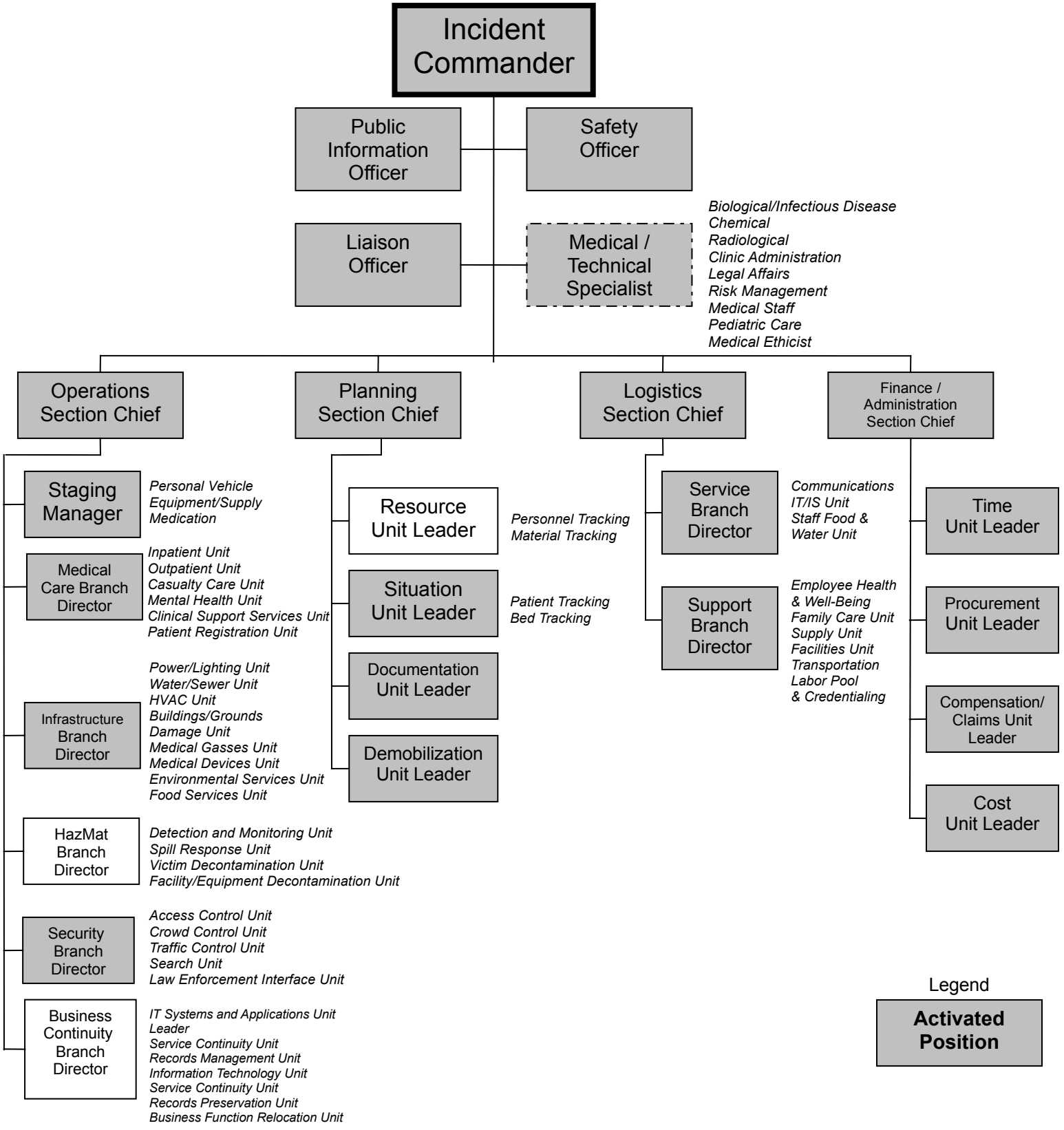
Documents and Tools:

☐	Hospital Emergency Operations Plan.
☐	Water Management Plan.
☐	Loss of Sewer & Flood Plan.
☐	Loss of HVAC Plan.

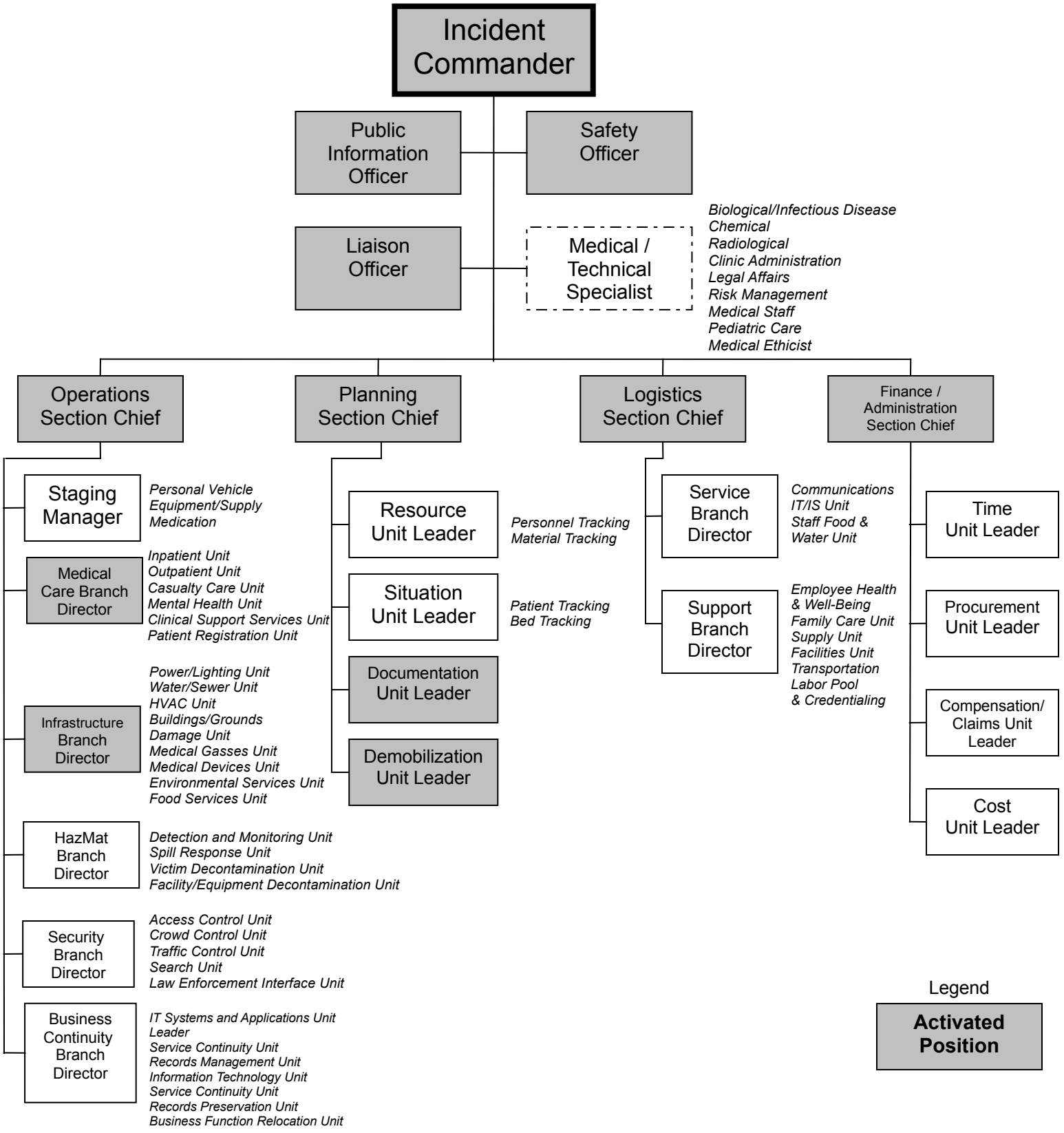
Appendix A: Water Management Plan Incident Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART - IMMEDIATE



Appendix A: Water Management Plan Incident Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART – INTERMEDIATE AND EXTENDED



Appendix A: Water Management Plan Incident Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART – DEMOBILIZATION



Descriptive Name: Water Management Plan

Descriptive Type: Revised

Document Number: 21-2026

Attachments: Included

Author: Lionel Machado

Typist: ~~Jennifer Bridges~~

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Emergency Management	~~09/17/13~~ 08-22-17	
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Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution – Administration

Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER
POLICY / GUIDELINE

TO: All Employees

FROM: Administration

SUBJECT: Earthquake

I. Purpose:

To provide an overview of the processes for responding efficiently and effectively. To return to full operation as quickly as possible following an earthquake that may impact the structural integrity of the facility, protection of staff, and to ensure the continuity of care for patients, visitors, and casualties of the event.

II. Scope:

Tulare Regional Medical Center and associated ~~clinics~~off site facilities.

III. Definition:

An earthquake is the result of a sudden release of energy at the surface of the earth, resulting from underground movement along a fault plane that creates seismic waves and has the potential to cause both, structural and non-structural damage to all or part of the facilities.

IV. Mitigation:

Mitigation activities and proactive efforts are in place to prevent a disaster from occurring, reduce the possibility of an event or reduce its impact on operations at Tulare Regional Medical Center. The following mitigation activities in place include:

A. Non-structural hazard mitigation such as: The proper arrangement, location and placement of items, seismic bracing and other construction designed to resist damage. Efforts are made to secure cabinets, shelves and furniture to prevent falling and blocking of egress paths. Large and/or heavy items are placed on lower shelves.

B. Cautious storage of hazardous materials (e.g., placement, secondary containment, berms, etc.).

C. Conformance to building and fire codes.

D. Inspection, testing and maintenance of emergency systems, such as the back-up information systems data.

E. The Hazard Vulnerability Analysis is conducted annually to ensure areas of exposure are addressed.

V. Preparedness:

Activities and plans designed to ensure preparedness, should disaster response become necessary include:

A. Use of the Incident Command System for emergency management and coordination with local response agencies.

B. Cache of disaster supplies, arrangements, and agreements for additional emergency supplies and resources.

C. Written emergency response protocols based on the hazard vulnerability analysis.

D. Staff training Emergency Preparedness Procedures Testing and maintenance of fire prevention features and systems.

E. Education and training of staff.

F. Alternate source of electricity (emergency generators).

G. Alternate communication program.

H. Drills to test the effectiveness of the response to the earthquake Plan.

VI. Response:

A. While the Earthquake is in progress (outside):

1. Get away from buildings and electric power lines.

2. If in a moving vehicle, pull over and stop. Avoid overpasses and power lines. Stay in the vehicle until the shaking stops.

B. While the Earthquake is in progress (inside):

1. Remain calm. DO NOT attempt to leave the building during the quake.

2. Move away from the windows, shelving, or other furnishing that may fall.

3. Take shelter under a sturdy desk or table or under a door frame, then “duck and cover” and hold on to something secure – crouch on the knees and protect the head with the arms; if no cover is available, “duck and cover” against an inside wall in the work area.

4. Don’t try to exit down stairwells during the shaking.

5. If in a wheel chair, move to cover beneath a doorway if possible, lock the wheels and protect head.

C. When the shaking stops:

1. Be prepared for additional after-shocks.

2. Proceed carefully. Floors may be covered with debris.

3. Account for all patients and staff members.

4. Rescue anyone in immediate danger. Check for people who might be trapped in exam rooms, nursing stations and other spaces.

5. Clear a path to exits from the work area.

6. Check for fires and extinguish them or summon help.

7. Identify any dangerous areas.

8. Be careful opening cupboards and closets, things may fall out.

9. Report any observed damage to department ~~supervisor~~Director.

10. Make rounds ~~of~~ on patients. If possible and necessary, move patients away from windows, overhead fixtures, and heavy equipment.

11. Do not use hospital phones for personal calls.

D. If off duty:

1. Do not call the Emergency Department, report for your regular shift unless recalled by the Hospital. Call the Hospital Disaster Hotline at 559-684-4525 for recorded disaster information.

2. Attend to the welfare of family members and check the residence for damage and/or utility disruption.

E. Activate the Earthquake Response Plan:

The Incident Commander will activate the ***Earthquake Response and Recovery Guide (Appendix A)*** based on the need due to damage and/or number of injuries, which have occurred at the facility and, in the surrounding neighborhood.

VII. Applicable and Regulatory Standards:

Accrediting Agencies

Hospital Incident Command System (HICS)

Questions concerning any aspect of this policy/guideline should be referred to Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

Appendix A: Earthquake Response and Recovery Guideline

Mission: To maintain Hospital operations following a major earthquake that may impact the structural integrity of the facility, and to ensure the continuum of care for patients, visitors, and casualties of the event.

Directions:

☐ Read this entire response guide and review incident management team chart.

☐ Use this response guide as a checklist to ensure all tasks are addressed and completed.

Objectives:

☐ Damage Assessment.

☐ Patients, visitors, staff assessed for injuries and accounted for.

☐ Continue patient care and support the community.

Immediate (Operational Period 0 – 2 Hours):

COMMAND

(Incident Commander):

☐ Activate the facility Emergency Operations Plan.
☐ Appoint Planning, Operations and Logistics Section Chiefs.
☐ Appoint Medical Technical Specialists – Hospital Administration, Clinical Administration and Risk Management, as appropriate.
☐ Assign a recorder to document all decisions/actions.

(Public Information Officer):

☐ Obtain information from the Situation Unit Leader to provide situation briefing to hospital patients, visitors, and staff.
☐ Update recorded Disaster Information message on the Hospital Disaster Hotline. If applicable, request radio and television stations to provide public service announcements.
☐ Evaluate a method for providing information for patients and family information.

(Liaison Officer):

☐ Communicate with the local Emergency Operations Center, local Public Health Department and officials to determine the extent of damage to critical infrastructure and services.
☐ Communicate with other Hospitals to determine status.
☐ Coordinate and communicate with Regional EOC or equivalent; notify as appropriate.

(Safety Officer):

☐ Conduct, in conjunction with Operations Section, an assessment of the facility to identify damaged and/or non-functional areas. If all or part of the facility is unable to be occupied, consider evacuation.

☐ Determine safe evacuation procedures and routes.
☐ Conduct ongoing analysis of existing response practices for health and safety issues related to staff, patients, facility, and implement corrective actions to address.

Appendix A: Earthquake Response and Recovery Guideline

OPERATIONS:

☐ Activate alternate care sites for evacuated patients.
☐ Implement evacuation of unsafe/unstable areas of the facility.
☐ Assess facility for damage, initiate repairs as appropriate or secure unsafe areas.
☐ Check the power plant and ensure that all vital functions are operating properly.
☐ Check all utilities and utility connections for damage (e.g., communication, fire alarm detection and suppression, HVAC, medical gases, sewage, and water).
☐ Inspect gas lines (natural gas, oxygen, air, nitrous oxide, etc.). If indicated, natural gas lines can be turned off until a thorough inspection of the facility indicates that it is safe to resume natural gas use.
☐ Activate search procedures, as appropriate.
☐ Assess the status of security systems, access and egress from facility, and implement the security plan.
☐ Prepare to receive incident casualties; establish triage and treatment areas, discharge areas and appropriate protocols.
☐ Conduct a census of inpatients, clinic patients, and those available for discharge.
☐ Receive briefings from the Directors regarding the number of injured.
☐ Ensure continued functioning of emergency power generators.
☐ Consider activating HazMat Branch if any facility damage resulting in hazardous materials spill or incident.

PLANNING:

☐ Initiate patient, bed, material and personnel tracking procedures.
☐ Establish operational periods and develop an Incident Action Plan in collaboration with the spill or incident.

LOGISTICS:

☐ Inventory and assess for damage: all supplies, equipment, food and water stores.
☐ Activate alternate communication systems and establish contact with local EOC, EMS and ensure intra-hospital communications with handheld radios, runners, etc.
☐ Project needs for 96 hours and institute rationing, if appropriate.

Intermediate (Operational Period 2 – Greater than 12 Hours):

COMMAND

(Incident Commander):

☐ Consider deploying a Liaison Officer to the local EOC, as appropriate.
☐ Ensure evacuation procedures are being conducted.

(Public Information Officer):

☐ Continue briefings to media, staff and patients.

☐	Establish the patient information center, in collaboration with the Liaison Officer.

Appendix A: Earthquake Response and Recovery Guideline

COMMAND:

(Liaison Officer):

- ☐ Continue to notify County EOC/local Public Health Departmentof situation status, critical issues and request assistance, as needed.
- ☐ Continue to communicate with local utilities about incident details and duration estimates.
- ☐ Continue patient information center operations, in collaboration with PIO.
- ☐ Continue communications with area hospitals and facilitate patient transfers.

(Safety Officer):

- ☐ Continue monitoring the evacuation of damaged areas; ensure safety practices in alternate care.

OPERATIONS:

- ☐ Continue patient care and management of inpatients, clinic patients and new casualties.
- ☐ Continue to manage alternate care sites and establish new sites as needed to accommodate evacuated or arriving patients.
- ☐ Determine the need for on-site housing and feeding of staff, in collaboration with the Logistics Section.
- ☐ Institute alternate care standards of practice (austere care) as appropriate to prioritize and manage the patient surge and lack of resources.

PLANNING:

- ☐ Update and distribute the Incident Action Plan.
- ☐ Revise the incident objectives, as needed, to meet the mission, in collaboration with the Incident Commander.
- ☐ Continue patient, bed, material and personnel tracking.

FINANCE/ADMINISTRATION:

- ☐ Track response expenses and compile estimates of repairs for facility damage.
- ☐ Facilitate procurement of supplies, equipment, medications and personnel for response.

Extended (Operational Period Beyond 12 Hours):

COMMAND

(Incident Commander):

- ☐ Review and revise incident objectives and the Incident Action Plan to reflect the current status and critical issues.
- ☐ Continue with Medical/Technical Specialists – Hospital Administration to ensure the continuity of operations.

(Public Information Officer):

☐ Continue regularly scheduled and as needed briefings to the media.
☐ Provide information updates to staff, patients and families.
☐ Continue patient information center activities.

Appendix A: Earthquake Response and Recovery Guideline

(Safety Officer):

☐ Continue to oversee safety of operations, repair and recovery operations.
☐ Continue to ensure the safety practices in alternate care sites, if activated.

OPERATIONS:

☐ Continue patient care and management activities.
☐ Reassess facility integrity after any earthquake aftershocks occur, and evacuate additional areas, if necessary.
☐ Reassess status of utilities (power, water, and sewer) and modify response plan, as needed.
☐ Ensure staff food, water and rest periods.
☐ Continue security operations and activities.
☐ Provide mental health support services to patients, families and staff.
☐ Assess the need for activating the Continuity Branch Director to ensure business operations are maintained.

LOGISTICS:

☐ Continue to monitor inventory of supplies, equipment, medications, food and water, and institute/continue rationing, as necessary.
☐ Maintain contact with vendor to ascertain re-supply timelines.

FINANCE/ADMINISTRATION:

☐ Continue tracking, monitoring and reporting response costs and personnel hours.
☐ Communicate with local, state, and federal emergency management to begin reimbursement procedures for cost expenditures related to the event.
☐ Contact insurance carriers to assist in documentation of structural and infrastructure damage and initiate reimbursement and claims procedures.

Demobilization/System Recovery:

COMMAND

(Incident Commander):

☐ Receive status reports from Section Chiefs to determine if normal hospital operations can be restored and the incident declared terminated.

(Public Information Officer):

☐ Conduct the final media briefing to update facility status, provide appropriate patient information and inform of return to normal operations.

☐ Demobilize the patient information center, in collaboration with the Liaison Officer.

(Liaison Officer):

☐ Communicate facility status and demobilization status to the local EOC/local Public Health Department, other area hospital and response partners.

☐ Demobilize the patient information center, in collaboration with the PIO.

Appendix A: Earthquake Response and Recovery Guideline

(Safety Officer):

☐ Determine the safety of the facility, ability to inhabit damaged but repaired areas, and protection of staff, patients and visitors.

OPERATIONS:

☐ Restore normal medical care operations.
☐ Oversee the movement of patients from alternate care sites into the Hospital facility/repaired areas.
☐ Continue to secure damaged, unsafe areas.
☐ Restore communication systems and utilities.
☐ Provide for mental health support services and stress management for patients, families and staff.

PLANNING:

☐ Prepare a summary of response operations, including number of patients received, status and current census.
☐ Write an after-action report and corrective action plan for approval by the Incident Commander to include the following:
- ☐ Summary of actions taken.
- ☐ Summary of the incident.
- ☐ Actions that went well.
- ☐ Area for improvement.
- ☐ Recommendations for future response actions.

LOGISTICS:

☐ Re-stock supplies, equipment and medications to normal levels.
☐ Compile financial facility damage and repair report.
☐ Conduct stress management services and debriefings for staff, as appropriate.

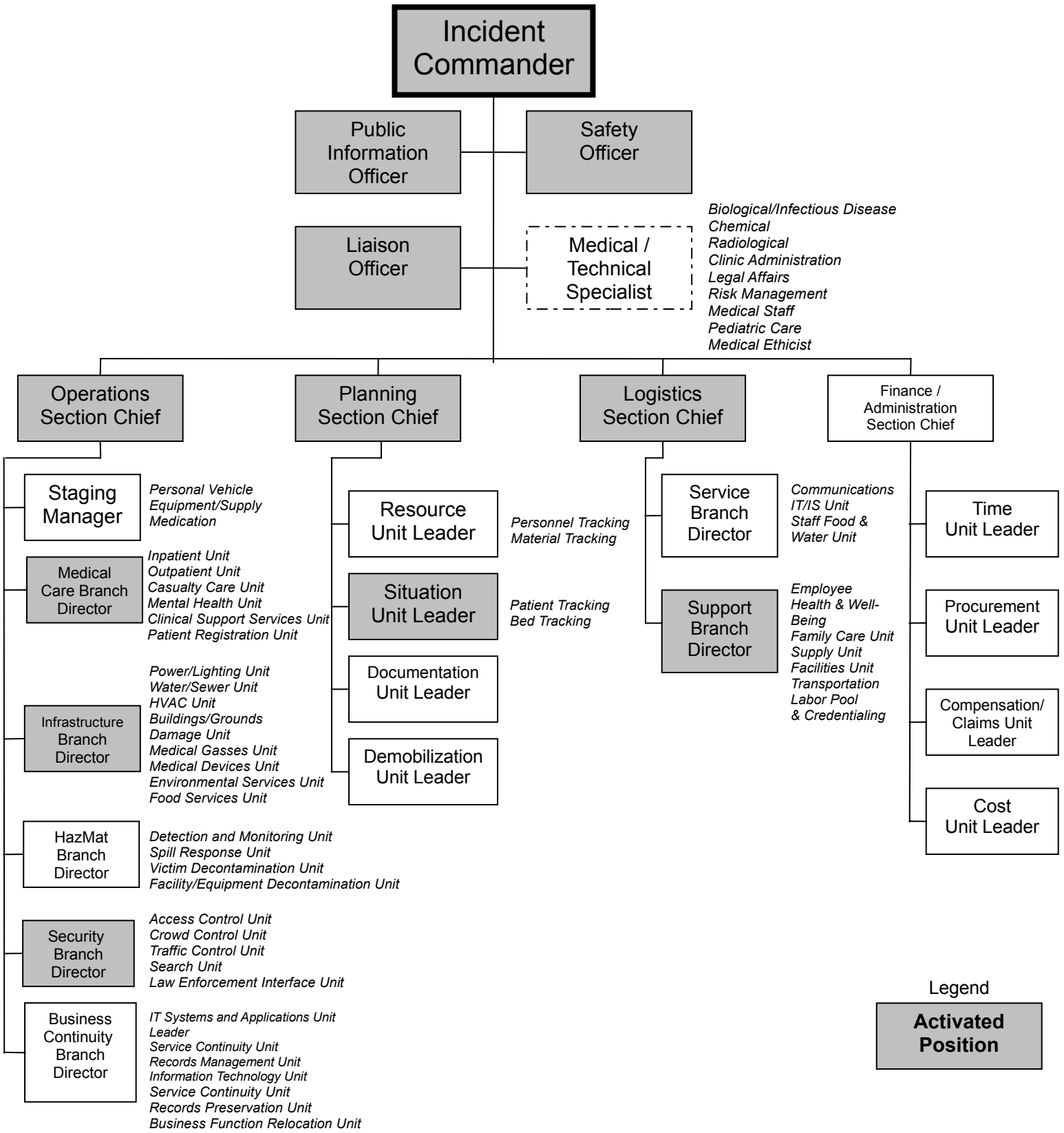
FINANCE/ADMINISTRATION:

☐ Prepare a final summary of response costs and expenditures for approval by the Incident Commander.
☐ Submit claims to insurance companies, as appropriate.
☐ Submit patient records and other appropriate information for reimbursement.

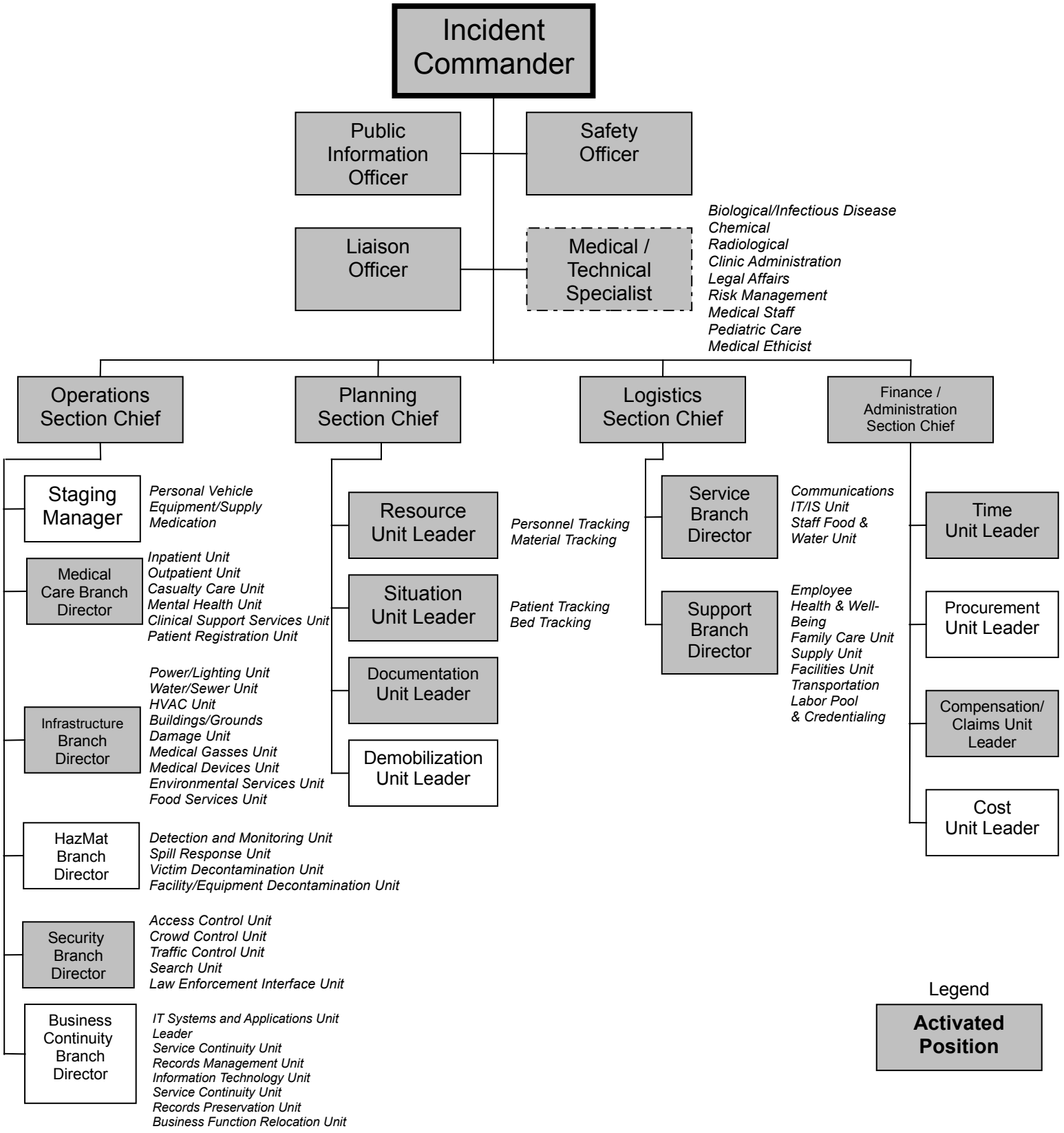
Appendix A: Earthquake Response and Recovery Guideline

Documents and Tools:	
☐	Hospital Emergency Operations Plan.
☐	Hospital Damage Assessment procedures and documentation forms.
☐	Discharge Policy.
☐	Emergency procurement policy.
☐	Patient Tracking.
☐	Staff activity forms.
☐	Interoperable communications plan.
☐	Utility Failure Plans (e.g., Water Management, Sewer failure/Internal Flood, Power Failure, etc.).
☐	Fire Plan and Fire Response Plan.
☐	Resource Inventory and MOUs.
☐	Search and Rescue Plan.
☐	Hazardous Materials Release Response Plan.
☐	Evacuation Plan and Evacuation Response Plan.

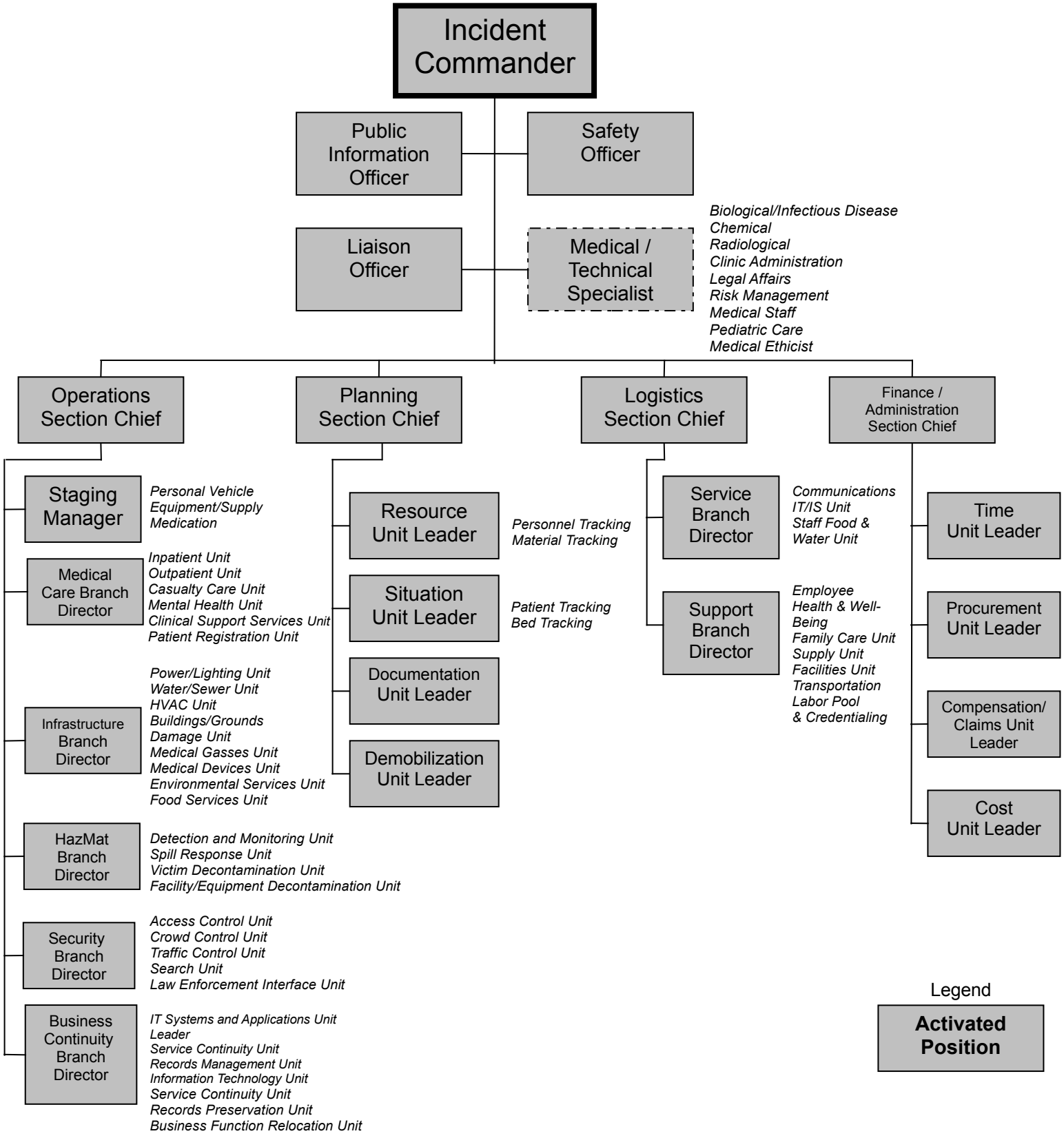
Appendix A: Earthquake Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART - IMMEDIATE



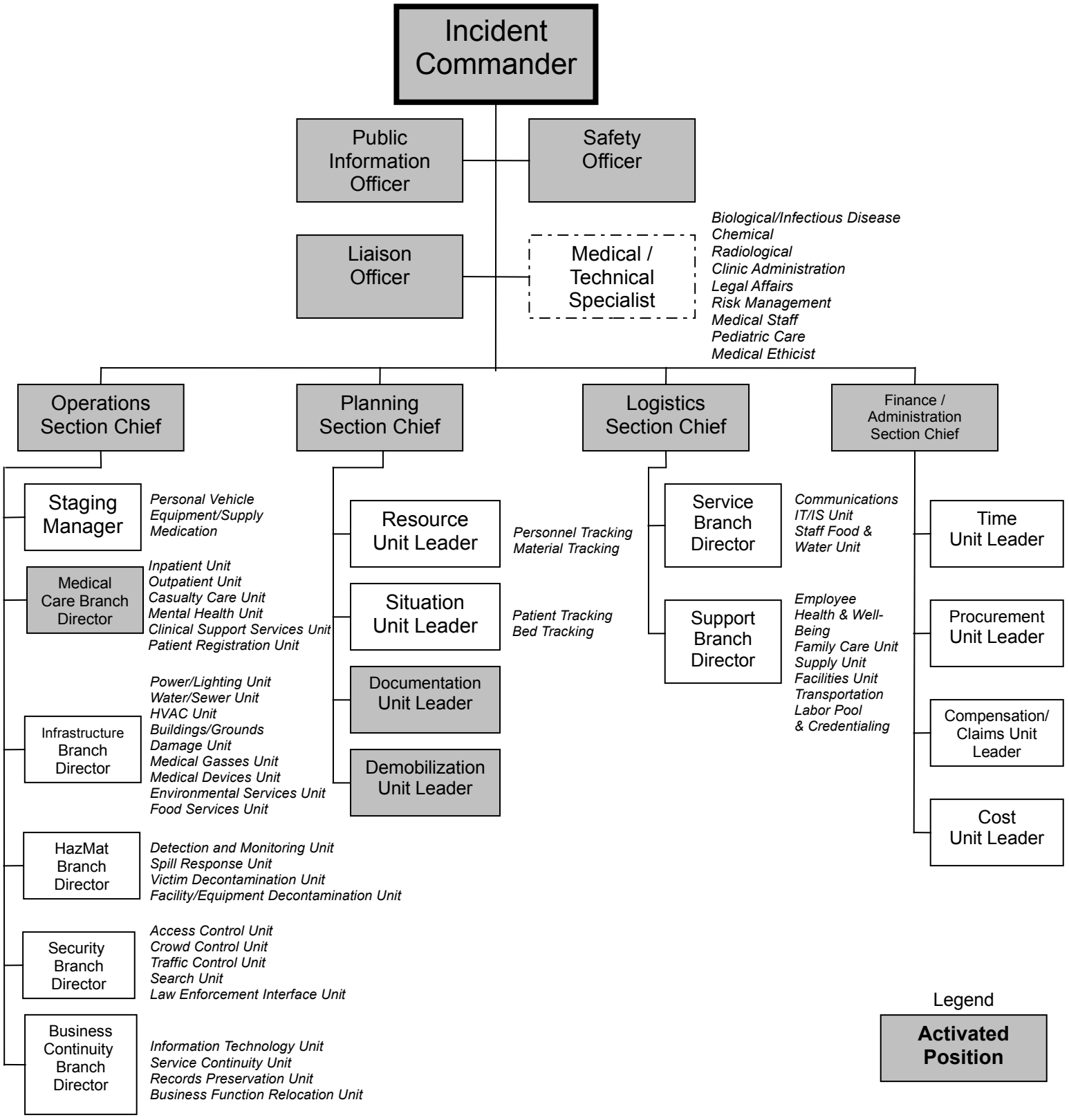
Appendix A: Earthquake Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART – INTERMEDIATE



Appendix A: Earthquake Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART – EXTENDED



Appendix A: Earthquake Response and Recovery Guideline
INCIDENT MANAGEMENT TEAM CHART – DEMOBILIZATION



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Author: Lionel Machado

Typist: ~~Jennifer Bridges~~Lionel Machado

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Comments:

TULARE LOCAL HEALTH CARE DISTRICT
dba TULARE REGIONAL MEDICAL CENTER

POLICY / GUIDELINE

TO: All Employees and Engineering Department

FROM: Administration

SUBJECT: Interim Life Safety Measures (ILSM)

I. PURPOSE:

It is the policy of Tulare Regional Medical Center to ensure that a safe environment is maintained during all construction of remodeling activities. The following document defines Tulare Regional Medical Center's procedures regarding implementation of Interim Life Safety Measures (ILSM) to address identified deficiencies in compliance with applicable National Fire Protection Association (NFPA) Life Safety Code (LSC). The ILSM may also be used during the time between the identification of building Life Safety System impairment and the Plan for Improvement (PFI) project complication.

II. SCOPE AND APPLICABILITY:

The ILSM program applies to all personnel and construction workers. ILSMS are applicable to Tulare Regional Medical Center and associated buildings. Those areas classified as business occupancy are exempt.

III. DEIFINITIONS:

A. **Interim Life Safety Measures** are a series of administrative actions implemented to ensure an equivalent level of protection is provided to the building occupants and to temporarily compensate for hazards posed by the impairment of the Life Safety features during construction or renovation projects, significant deficiencies compromise built in life safety systems, or anything which will effect egress or safety systems or will increase fire hazards.

B. **Fire Watch** is defined by the National Fire Protection Association (NFPA) as the assignment if a person or persons to an area for the express purpose of notifying the fire department and /or building occupants of an emergency, preventing a fire from occurring, extinguishing small fires, or protecting the public from fire or life safety dangers.

C. **Pre-Construction Risk Assessment (PCRA)** is a tool used to identify risks

and mitigation measures prior to starting construction.

D. Office of Statewide Health Planning & Development (OSHPD) monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to assist the capital needs of California's not-for-profit healthcare facilities.

IV. REQUIREMENTS:

A. The Interim Life Safety Measures (ILSM) will be assessed. If ILSMs are implemented to temporarily compensate for significant hazards posed by existing NFPA Life Safety Code deficiencies or construction activities, failure to follow these guidelines will result in cessation of work.

B. A copy of this policy shall be given to all contractors and personnel whose actions may result in the creation of dust, smoke, heat, fumes, etc. which may in turn, cause a fire alarm to activate.

C. In the event the fire alarm system or component is unexpectedly impaired, the Department of Engineering shall be immediately notified.

V. PROCESS:

A. Project Requests:

1. Department Directors may submit construction or remodeling request to the ~~Facility~~ Engineering Department for review through written request, using the follow guidelines:

   a. Requests for review are to be made during the consideration phase of or purchase to allow adequate time for review, site visit, planning for supplemental needs (wiring, outlets, etc.), and OSHPD design and approval processes (if required).

   b. Projects will be prioritized based on patient necessity, timing, departmental need, regulatory requirements and availability of resources.

B. Assessment of ISLM:

1. The Interim Life Safety Measure (ILSM) will be assessed prior to renovation or construction activities or when NFPA safety Code deficiencies are identified that:

   a. Require entry into the Statement of Condition (eSOC) and corrective action plan.

b. Is maintenance oriented and subject to the provisions of an established building maintenance oriented and subject to the provisions of an established building maintenance plan (BMP) but cannot be corrected within 45 days.

c. Is recognized that not all deficiencies in LSC will rise to the level of requiring implementation of ILSM. However, those deficiencies that meet the requirements set forth in this policy shall, at a minimum, be evaluated for the need for ILSM.

d. The organization shall maintain sufficient records to demonstrate ILSM evaluation/implementation occurred when required by this policy.

VI. PURPOSE:

A. If a project is selected to proceed the Facility Director will assemble a planning team with members essential to the project such as:

- Safety Officer
- Chief Operations Officer
- Director of Engineering
- Infection Preventionist
- Contractor
- Department Director
- Hospital contracted Architect of Record
- Hospital contracted Inspector of Record for OSHPD (IOR)

B. The Facility Planning Team ensures that prior to the start of any project, risks are adequately assessed, and the appropriate interim measures are selected and implemented for all construction and/or renovation projects.

C. The following tools will be utilized:

1. The **Interim Life Safety Measure Evaluation Form (Attachment 1)**, which ensures consistent evaluation, application, and documentation of ILSM.

2. The **Fire Watch Log** is used to document the fire watch.

3. The **ILSM/PCRA Daily Inspection Checklist** is used to document the increased surveillance of the project area and actions to minimize risks.

D. Deficiencies that cannot be corrected will be reviewed for ILSM's based upon criteria in the policy.

E. Copies of all documentation will be provided to the Director of Engineering/Safety Officer.

VII. ROLES AND RESPONSIBILITIES:

A. Project Director (For Construction Related Activities):

1. Complete the ***ILSM Evaluation Form*** for each construction project, with the assistance of the Contractor or Hospital staff performing the work.

2. Present the completed ILSM Evaluation Form to the Facility Planning Team for review and approval.

3. Verify that fire alarm, detection, and suppression systems are not impaired. Coordinate with the Contractor or Hospital Staff performing the work, the Implementation of a temporary, but equivalent, system when any fire system impaired.

4. Temporary systems must be documented, inspected and tested monthly.

5. Notify/coordinate with the Engineering Department for utility shutdown. When any part of the fire alarm system or fire suppression system is going to be out for work, notify the Director of Engineering or designee.

6. Notify the local Fire Department, as necessary. Keep records of all inspections that relate to Fire Safety. Send copies of inspections to the Director of Engineering/Safety Officer.

7. Verify, with the assistance of the Contractor or Hospital staff performing the work, that free and unobstructed exits and access to emergency services (e.g. fire, police, and other) are maintained.

8. Ensure affected staff receives additional information/communication when alternative exits are designated.

9. Notify the Engineering Department that "***ILSM/PCRA Daily Inspection Checklist***" forms are required in construction area, as necessary. Verify, with the assistance of the Contractor or Hospital staff performing the work, the current "***ILSM/PCRA Daily Inspection Checklist*** is maintained for each affected project. Any deficiencies noted are to be

followed-up with immediately and documented on the bottom of the Inspection Form.

10. Verify, with the assistance of the Contractor or Hospital staff performing the work, that the current **Fire Watch Log** is maintained for each affected project, as necessary.

11. Ensure completed original copies of ***ILSM Form***, ***ILSM/PCRA Daily Inspection Checklist*** and **Fire Watch Logs** are submitted to the Engineering Department for filing.
12. Indicate to the Contractor or Hospital staff performing the work that construction storage and office buildings are NOT to be located in proximity to the Hospital such that a fire could spread.

13. Discuss any ILSM issues with the Engineering Director/Safety Officer.

14. Smoking shall be prohibited. Emphasize this requirement at the pre-construction meeting and record in the minutes of the meeting. Ensure that bidders review ILSM together with bid documents.

B. The Director of Engineering:

1. Will complete the ***ILSM Evaluation Form*** to assess for any existing deficiencies or groups of deficiencies of the LSC and present the completed ILSM Evaluation Form to the Facility Planning Team for review and approval.

2. Upon notification that a fire system needs to be worked on by-passed or taken off-line, Engineering will perform a site inspection and verify that the mitigation measures identified on the ***ILSM Evaluation Form*** (e.g. notification of personnel affected, fire watch) is implemented.

3. Once the contractor notifies Engineering that work is complete, Engineering will ensure that the system is restored to normal.

4. Conduct a minimum of one additional fire drill per shift per quarter, if warranted, and document the need in the ***ILSM Evaluation Form***.

5. Provide fire watch, as indicated on the ***ILSM Evaluation Form***, during non-construction work hours (e.g. nights and weekends).

6. Ensure all temporary system (e.g. fire alarm, detection, and suppression systems) are documented, inspected and tested monthly.

C. Project Contractor/TRMC Personnel:

1. Assist Project Director with the completion of the ***ILSM Evaluation Form*** and abide by mitigation, measures, as necessary.

2. Complete the ***ILSM/PCRA Daily Inspection Checklists*** required in the construction area, as necessary. Conduct surveillance of construction buildings, grounds and equipment with special attention to excavations, construction storage and field offices. Excavations are to be barricaded and well lit at night. Ensure housekeeping and debris removal of construction areas at the end of each day.

3. Ensure that appropriate fire exit routes are maintained. When fire exits are blocked due to construction, alternate fire exits must be provided and inspected daily.

4. Install highly visible fire exit signs to alternate fire exit routes.

5. Ensure free and unobstructed exits.

6. Ensure access to fire, police, and other emergency forces.

7. Ensure staff receives additional information/communication when alternate exits are designated.

8. Develop and enforce storage, housekeeping and debris removal policies and procedures that reduce the flammable and combustible fire load to the lowest level necessary for daily operations. Review these items with the general contractor or alert the Environmental Services Department for assistance with debris removal and housekeeping services.

9. Install temporary partitions that are smoke tight and built of noncombustible materials, approved by the local authority having jurisdiction.

10. Provide additional fire extinguishers and firefighting equipment and train personnel to use this equipment, as determined in the ***ILSM Evaluation Form***. Keep a record of training.

11. During construction work hours, provide fire watch as directed in the ***ILSM Evaluation Form***. Notify Security or Engineering at the end of the work shift to assume responsibility of the fire watch.

12. When the work has been completed, or at the end of a normal workday, notify Engineering.

13. Storage, housekeeping, and debris removal practices are used to reduce the flammable and combustible fire load to the lowest level necessary for operations.

14. All construction personnel observe the Hospital's "Smoking Policy".

15. All temporary fire alarm, detection, and suppression systems are unobstructed.

D. Safety Officer:

1. If hazards are identified as a result of construction activities, the Safety Officer will work with Department Directors to ensure corrective action(s) are taken and ensure that staff members are knowledgeable about any changes in fire safety features of their work area.

2. Ensure facility wide safety education programs are provided to promote awareness of fire safety building deficiencies, construction hazards, and ILSM.

3. Report safety hazards to the Safety (Environment of Care) Committee.

E. Security:

1. Ensure free and unobstructed access for fire, police, and other emergency forces.

2. A dedicated fire watch must be provided when any fire alarm, detection, or protection system has been rendered inoperable or will be out of service for more than four (4) hours in a twenty-four hour period in an occupied building. This applies to all detection loop systems and parts of systems on any occupied floors or rooms that would have an adverse effect on the fire and life safety of the occupants of the building.

3. Qualified assigned person(s) will conduct a fire watch. They will be responsible for the continuous patrol of a building or premises for the purpose of detecting fires and transmitting an immediate alarm to the building occupants and Fire Department. The fire watch person must be trained and be familiar with:

a. The procedure for notifying the fire department.

b. A method to alert building occupants.

c. The evacuation procedure.

d. The location and use of fire protection equipment, such as fire extinguishers.

4. The assigned fire watch staff shall be thoroughly familiar with the areas they are patrolling and be equipped with communication devices for the transmission of emergency alarms.

5. The fire watch shall be on continuous watch until the system or systems are restored to service.

6. The assigned fire watch person(s) shall perform rounds in work areas at a minimum of once per hour. Rounds and ongoing fire/life safety activities shall be documented on the ***Fire Watch Log***; which will be maintained on the premises and be available for inspection by the authority having jurisdiction.

F. Department Directors:

1. Department Directors are responsible for training and maintaining training records for employees affected by ILSM procedures.

G. Hospital Staff

1. Participate in emergency evacuation training and use the alternate fire exits established for the construction phase.

2. Participate in ILSM fire drills, as necessary.

VIII. MITIGATION:

A. The facility will evaluate the nature, scope, severity, and anticipated duration of the LSC deficiency in determining the specific ILSM that should be implemented. Prior to starting projects, utilize the following table for risk mitigation actions that may include, but are not necessarily limited to the following:

INTERIM LIFE SAFETY MEASURES When the hospital identifies Life Safety Code (LSC) deficiencies that cannot be immediately corrected or during periods of construction, the following actions are taken:	**RISK MITIGATION ACTIONS**
1. Inspect exits in affected areas on a	• If exiting is obstructed, signage

INTERIM LIFE SAFETY MEASURES When the hospital identifies Life Safety Code (LSC) deficiencies that cannot be immediately corrected or during periods of construction, the following actions are taken:	**RISK MITIGATION ACTIONS**
daily basis.	should be posted redirecting people to active exits. • The normal/alternate exit and discharge paths are to remain accessible at all times. The alternate exit should be clearly marked. • When alternate exits are designated, communication will be made to staff affected by the change, and information about the alternate exit provided. • Construction workers should be made aware of egress routes. • Free and unobstructed access for fire, police and other emergency response agencies will be enforced. • The ***ILSM/PCRA Daily Inspection Checklist*** will be used to document that the means of egress was inspected.
2. Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired.	• The hospital fire alarm system is continuously monitored to correct any trouble or alarm conditions. • Whenever the fire alarm system operation is compromised by construction, an announcement will be made by overhead page notifying all staff and reminding them to call " x77 to report a code red. • A temporary system for fire alarm and suppression (such as a fire watch) will be provided when any fire system is disabled and the fire

INTERIM LIFE SAFETY MEASURES When the hospital identifies Life Safety Code (LSC) deficiencies that cannot be immediately corrected or during periods of construction, the following actions are taken:	**RISK MITIGATION ACTIONS**
	department will be notified.
3. Provides additional firefighting equipment.	• Additional temporary firefighting equipment will be maintained at the construction site. • Contractors will be responsible for training their own employees and subcontractors in the use of this equipment.
4. Uses temporary construction partitions that are smoke-tight, or made of noncombustible material, or made of limited combustible material that will not contribute to the development or spread of fire.	If the project includes any high-risk construction techniques (e.g. torch cutting, welding, burning) barriers will be erected of non-combustible or limited combustible materials that will not contribute to the development or spread of fire.
5. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas (e.g. storage, excavation, and field offices).	The ILSM/PCRA Daily Inspection Checklist will be used to document the increased surveillance of buildings, grounds and equipment including storage, field offices and areas of excavation.
6. Enforces storage, housekeeping, and debris removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.	• Construction debris will be kept to a minimum and excess combustible material be removed at the end of each workday. • Storage and debris removal will be evaluated and documented on the ILSM/PCRA Daily Inspection Checklist. • All welding, brazing and soldering shall take place only in designated areas where the risk of combustion due to sparks has been minimized.

INTERIM LIFE SAFETY MEASURES When the hospital identifies Life Safety Code (LSC) deficiencies that cannot be immediately corrected or during periods of construction, the following actions are taken:	**RISK MITIGATION ACTIONS**
7. Provides additional training to those who work in the Hospital on the use of firefighting equipment.	The ILSM will be assessed to determine what information and training is needed in regards to the ILSM. If it is determined that staff require education on hazards, LSC deficiencies and ILSM, education will be provided.
8. Conducts one additional fire drill per shift per quarter.	ILSMs will be assessed. If determined, additional fire drills will be conducted when a building does not meet the applicable provisions of the Life Safety Code. This ensures staff is familiar with altered conditions and exiting routes. Document the drill on the ***TRMC Fire Drill Critique form.***
9. Inspects and tests temporary systems monthly. There is documentation of the completion date of the tests.	Any temporary system must be inspected and tested monthly and will be documented in the ~~Teamops~~ preventative maintenance record.
10. The Hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety.	The ILSM will be assessed to determine when staff needs information and training regarding the ILSM. If determined that staff require education on hazards, LSC deficiencies and ILSM, education will be provided.
11. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features.	Staff in affected areas and in areas adjacent to construction sites will be provided with training regarding the alternate fire safety features undertaken to maintain safety.

IX. DOCUMENTATION TOOLS:

- Attachment 1 – ILSM Evaluation Form
- Attachment 2 - Fire Watch Log
- Attachment 3 – ILSM/PCRA Daily Inspection Checklist

- Attachment 4 – Tulare Pre-Construction Risk Assessment
- Attachment 5 - Table 2: Type Of Construction

X. APPLICABLE REGULATIONS & STANDARDS:

- Joint Commission Life Safety
- DNV; PE.2, SR.7
- CMS; Conditons of partcipation, 482.41 (b)
- National Fire Protection Agency Life Safety Codes

Questions concerning any aspect of this policy/guideline should be referred to Human Resources or Administration.

This policy/guideline replaces and supersedes all previous policies/guidelines concerning this matter and is effective immediately.

INTERIM LIFE SAFETY MEASURE (ILSM) EVALUATION FORM

Note: "X" denotes ILSM is required / considered.

CHECK (√) IF THIS CONDITION EXISTS	Existing Significant Life Safety Code Deficiencies Or Conditions Created By Construction Activity	Inspect Exits in affected areas, daily	Post signage for alternate exits, educate personnel	Notify Emergency Forces, conduct fire watch	Ensure Operational Life Safety Systems	Erect Temporary Construction Barriers	Provide Additional Fire Fighting Equipment	Prohibit Smoking	Control Combustible Loading	Conduct One Addl. Fire Drill per Shift Per Quarter	Increase Environmental Rounds	Inspect and test temporary systems monthly	Train personnel on firefighting equipment	Train all personnel on defic. hazards, fires safety	Train personnel on compartmental fire safety
	Life Safety Code Deficiencies														
	Patient room doors do not latch properly						X	X	X	X	X				X
	Smoke barrier does not exist or is not code compliant						X	X		X	X				X
	Fire exit stairs discharge improperly		X					X		X			X	X	X
	There is an excessive travel distance to an approved exit							X	X	X	X		X		
	There are not two remote exits							X	X	X	X		X	X	X
	Building construction type is non-conforming						X	X	X	X	X			X	
	Vertical openings are improperly protected							X	X	X	X				X
	Fire barriers have large penetrations							X	X	X	X			X	X
	Corridor walls do not extend to the structure							X	X	X	X				X
	Hazardous areas are not properly protected							X	X		X				
	Obstructing approved exits	X	X	X				X	X	X	X		X	X	X
	Rerouting traffic to the Emergency Department			X				X							
	Renovating an occupied floor (major renovation)	X			X	X	X	X	X	X	X				X
	Replacing the fire alarm system (out of service)				X			X	X	X	X		X		
	Installing the sprinkler system (out of service)				X		X	X	X	X	X			X	

	Significantly modifying smoke or fire barrier walls					X		X	X	X	X		X		X
	Constructing an addition to an existing structure	X			X	X		X	X					X	
	Maintenance And Testing														
	Disabling a fire alarm system			X	X			X				X	X		
	Disabling a sprinkler system			X	X			X				X	X		
	Disconnecting alarm device			X	X			X				X			
	Other														

Project Title/No.: _____ Project Manager Signature: _____ Date: _____

A. **Fire Watch Log**

Fire watch personnel have been trained and/or have the following qualifications:

- Can gain access to all areas of the building under the fire watch.
- Can recognize signs of fire or other hazards that could cause injury.
- Know evacuation routes.
- Can manually alert building occupants by sounding alarm, whistle, etc.
- Can use portable fire extinguishers.
- Can patrol their assigned building area once every hour.
- Can properly complete the fire watch log.

Location:			
Date of Activation		**Reason for Fire Watch**	
Fire Watch Time*	**Status/Problems Encountered**	**Actions Taken**	**Signature**

Tours must be conducted at least every hour

PCRA/ILSM Daily Inspection Sheet

This checklist must be completed daily (2 pages).

PROJECT:								**DATE:**	
CONTRACTOR:								**INSPECTOR:**	
ILSM:									
Requirements	Completed P=Pass, F= Fail or N/A = Not Applicable							Comments	Project Director or Designee Signature Required if Deficiencies Are Found
EXITS	S	M	T	W	TH	F	S		
The normal/alternate access, exit and discharge paths are accessible.									
If exiting is obstructed, signage is posted redirecting people to active exits.									
When alternate exits are designated, staff affected by the change has received information about the alternate exit provided.									
Construction workers have been informed of egress routes.									
Free and unobstructed for fire, police and other emergency response agencies is enforced.									
Walkways are sufficiently clear for emergency response and egress.									
Fire Safety and Equipment									
When the fire system is disabled, a temporary system for fire alarm and suppression, such as a fire watch, has been provided.									
The fire department has been notified (when the fire system is disabled).									
Hot work permits are available.									
No Smoking Policy been implemented?									
Additional temporary firefighting equipment is available.									
Construction areas are free of excess storage & construction debris, and housekeeping is conducted.									
Barriers erected of non-combustible or limited combustible materials that will not contribute to the development or spread of fire. (Sheetrock if project longer than 3 days)									

PROJECT:								**DATE:**	
CONTRACTOR:								**INSPECTOR:**	
ILSM:									
Increased surveillance of buildings, grounds and equipment including storage, field offices and areas of excavation has been conducted.									
Additional fire drill conducted.									
Security									
Lockable doors in use?									
General Safety									
Power properly secured at the end of each day.									
Hard hats and other appropriate personal protective equipment is in use where required.									
Cutting and welding operations are properly conducted.									
Excavations, scaffolding and work requiring fall protection are conducted safely.									
Infection Control Measures									
Work area has negative pressure.									
Traffic patterns for workers with debris are being followed.									
Debris is covered.									
Are methods of debris transport monitored and found to be consistent with a process designed to minimize release of particulate matter?									
No dust/debris visible outside project area.									
Walk off mat/tack mat in use and clean.									
Project cleaned at the end of the day.									
Hazardous Materials/Waste & Air Quality									
Engineering and Safety are informed of any hazardous substances brought to the site and the applicable MSDS(s) have been provided to the Safety Officer and posted at the construction site?									
All compressed gases secured?									
There is appropriate use of HEPA filters, vacuums, and exhaust fans.									
Doors properly closed and sealed.									
Noise									
Patients, staff, construction workers, or visitors will not be exposed to high noise levels that could cause hearing loss and/or create physical or psychological stress.									
Utility Systems									

PROJECT:								**DATE:**	
CONTRACTOR:								**INSPECTOR:**	
ILSM:									
Procedures are in effect to prevent adverse outcomes to patient care (e.g. water, plumbing, electrical failures).									
Temporary extension cords are kept to a minimum and care taken to not overload existing circuits.									

Tulare Regional Medical Center

Pre-Construction Assessment

Evaluation Date:

Directions:
This form is to be used prior to initiating construction, renovation, or remodeling of facility buildings. Appropriate parties should participate in the planning assessment. Form to be completed b project lead.

PROJECT TITLE: _____

PROJECT DESCRIPTION:_____

_____

PROJECTED START DATE: _____ PROJECTED COMPLETION DATE: _____

DISCIPLINES INVOLVED (check all that apply)

- ❑ Engineering
- ❑ Infection Control
- ❑ Administration
- ❑ Environmental Svcs.
- ❑ Nursing
- ❑ Respiratory Therapy
- ❑ Diagnostic Imaging
- ❑ Clinical Lab
- ❑ Clinics
- ❑ Rehab Services
- ❑ Security
- ❑ Other: _____

SECTION ONE – INTERIM LIFE SAFETY MEASURES (ILSM)

MODIFICATION OF LIFE SAFETY FEATURES (Check all that apply)	ILSM' REQUIRED (Check all that apply)
This project will impact the following life safety features: ❑ No modification of life safety features identified ❑ Identified exits from area ❑ Free and unobstructed egress from area ❑ Free and unobstructed access / egress to / from the Emergency Department ❑ Activation of fire alarm detection system(s) ❑ Activation of fire suppression systems ❑ Configuration of smoke compartments ❑ Integrity of fire walls / doors ❑ Integrity of smoke dampers ❑ Building of temporary construction partitions ❑ Amount of flammable / combustible load ❑ Staff knowledge of life safety system(s) ❑ Fire response procedure	The following ILSM measures to be implemented: ❑ No ILSM required ❑ Identify and label alternate exits / egress from area. ❑ Develop plan to assure access / egress from ED ❑ Notify local fire authority if fire alert / suppression system inactive for more than 4 hours ❑ Ensure temporary construction partitions are smoke tight and built of non-combustible materials ❑ Provide additional fire fighting equipment ❑ Conduct additional fire drill per shift / per quarter ❑ Implement fire watch ❑ Increase hazard surveillance rounds in area Required for any ILSM Project ✓ Minimize combustible / flammable load ✓ Prohibit smoking in construction and adjacent areas. ✓ Provide appropriate training to affected staff ✓ Provide organization-wide training on construction

	hazards and ILSM

SECTION TWO – NOISE ASSESSMENT

Noise Generation During Construction (Check all that apply)			Interventions Required (Check all that apply)
Type	**Severity**	**Duration**	
❑ Drilling ❑ Blasting ❑ Pounding ❑ Heavy Equip. ❑ Motors ❑ Other	❑ Low ❑ Mild ❑ Moderate ❑ High ❑ Severe	❑ Short ❑ Brief ❑ Intermittent ❑ Frequent ❑ Prolonged ❑ Continuous	❑ No special interventions required ❑ Notify affected areas prior to noise producing activity ❑ Relocate patients / staff to another area of the facility for duration of activity ❑ Schedule activity during non-working hours or when department closed ❑ Provide hearing protective equipment ❑ Other: _____

SECTION THREE – AIR QUALITY ASSESSMENT

Air Quality Issues During Construction (Check all that apply)			Interventions Required (Check all that apply)
Type	**Severity**	**Duration**	
❑ Fumes ❑ Dust ❑ Mold ❑ Smoke ❑ Chemicals ❑ Other	❑ Low ❑ Mild ❑ Moderate ❑ High ❑ Severe	❑ Short ❑ Brief ❑ Intermittent ❑ Frequent ❑ Prolonged ❑ Continuous	❑ No special interventions required ❑ Restrict / shut down air handlers for duration of activity ❑ Provide negative pressure / HEPA filtration ❑ Relocate patients / staff to another area of the facility for duration of activity ❑ Schedule activity during non-working hours or when department closed ❑ Provide respiratory protective equipment ❑ Other: _____

SECTION FOUR – VIBRATION ASSESSMENT

Vibration Issues During Construction (Check all that apply)			Interventions Required (Check all that apply)
Type	**Severity**	**Duration**	
❑ Primary ❑ Secondary ❑ Other	❑ Low ❑ Mild ❑ Moderate ❑ High ❑ Severe	❑ Short ❑ Brief ❑ Intermittent ❑ Frequent ❑ Prolonged ❑ Continuous	❑ No special interventions required ❑ Evaluate for “seismic” related interventions ❑ Notify work areas prior to activity ❑ Relocate patients / staff to another area of the facility for duration of activity ❑ Schedule activity during non-working hours or when department closed ❑ Other: _____

SECTION FIVE – UTILITY ASSESSMENT

Utility Issues During Construction (Check all that apply)			Interventions Required (Check all that apply)
Type	**Impact**	**Duration**	
❑ HVAC ❑ Medical Gas ❑ Power ❑ Water ❑ Suction ❑ Other	❑ Modified Operational ❑ Shut Down ❑ Other	❑ Short ❑ Brief ❑ Intermittent ❑ Frequent ❑ Prolonged ❑ Continuous	❑ No special interventions required ❑ See specific procedures for utility shut down ❑ Notify work areas prior to activity ❑ Relocate patients / staff to another area of the facility for duration of activity ❑ Schedule activity during non-working hours or when department closed ❑ Other: _____

SECTION SIX – INFECTION CONTROL ASSESSMENT (see "IC Precautions for Construction" Reference Tool)

Infection Control During Construction (Check all that apply)		Interventions Required (Check all that apply)
Type	**Risk Group**	
❑ Type A ❑ Type B ❑ Type C ❑ Type D	❑ Low Risk ❑ Medium Risk ❑ Medium to High Risk ❑ Highest Risk	❑ Class I ❑ Class II ❑ Class III ❑ Class IV ❑ Other: _____

SECTION SEVEN – EMERGENCY PROCEDURES
Are any emergency procedures affected by this project? ____ Yes ____ No (if yes, note procedure, issue, and plan)

_____

_____

TYPE OF CONSTRUCTION

TYPE	CLASS OF PROJECT	DESCRIPTION	TYPICAL ACTIVITIES	RISKS
A	INTERNAL MINIMAL (single phase, short duration)	Inspection or non-invasive procedures, no dust, no aerosols created, little or no odors, little or no noise, little or no vibrations, no sanding, no cutting of walls, no disturbance of asbestos, no EMI*, & no scraping.	Routine maintenance, removal of ceiling tiles for inspections, painting, wall covering, cleaning.	Little or no risk to patients, minor disruption of services and/or utilities.
B	INTERNAL MINOR (single phase, short duration < one day)	Small scale, short duration, minimal dust/noise/ vibration/odor, no aerosols created, minor penetration of walls/ceilings/floors, no disturbance of asbestos, and no EMI.	Routine repairs, installation of cables, painting, minor sanding or scrapping	Little risk to patients, dust, odors, noise, vibrations, hazardous chemicals, & disruption of services and/or utilities.
D	INTERNAL SUBSTANTIAL (one or more phase or tasks, longer duration > one day)	Work that creates dust, aerosols, fumes, smoke, heat, vapors, noise, vibrations, odors, disturbance of asbestos, minor EMI, and/or penetrations of walls/ceilings/floors.	Demolition or removal of building components (walls, ceilings or floors), sanding, construction, major cabling, major repairs, major plumbing, major electrical work, major roof repair, & scrapping.	Nosocomial illnesses, dust, odors, noise, vibrations, hazardous chemicals, asbestos, fire, electrical, IAQ**, water damage, EMI & disruption of services and/or utilities.
F	INTERNAL MAJOR (one or more phase or tasks, longer duration > one month)	Work that creates high levels of dust, aerosols, fumes, smoke, heat, vapors, long duration (> 1 month), high noise, high vibrations, possible EMI, penetration of interior wall/floors/ ceilings, disturbance of asbestos, and/or odors.	Major demolition and/or major construction, & removal of building components.	Nosocomial illnesses, dust, odors, noise, vibrations, hazardous chemicals, asbestos, fire, electrical, IAQ, water damage, EMI & disruption of services and/or utilities.
C	EXTERNAL MINOR (single phase, short duration <one day)	Small scale, minimal dust, aerosols, fumes, smoke, heat, vapors, odors, noise, and/or vibrations (not transmitted inside building). No EMI. Outside of building envelope without penetration	Minor construction projects, digging, repairs, minor roof repair, & painting.	Little or no risk to patients, Nosocomial illnesses, dust, odors, noise, & disruption of services and/or utilities.
E	EXTERNAL SUBSTANTIAL (one or more phase or tasks, longer duration > one day)	Larger scale work of longer duration (> one day) that creates dust, aerosols, noise, vibrations, EMI, fumes, smoke, heat, vapors and/or odors. Some penetration of exterior walls/roof possible	Demolition and/or construction, removal of building components, sanding, major cabling, & scrapping.	Nosocomial illnesses, dust, odors, noise, vibrations, hazardous chemicals, fire, possible IAQ, EMI & disruption of services and/or utilities.
G	EXTERNAL MAJOR (one or more phase or tasks, longer duration > one month)	Major work of long duration that creates high levels of dust, aerosols, noise, vibrations (transmitted inside building), fumes, smoke, heat, vapors, EMI and/or odors. Outside of building with penetration of exterior walls/roof possible.	Major demolition and/or major construction, use of heavy equipment.	Nosocomial illnesses, dust, odors, noise, vibrations, hazardous chemicals, fire, IAQ, EMI & disruption of services and/or utilities.

*EMI = Electro-Magnetic Interference
**IAQ= Indoor Air Quality

NOTE: If projects are both inside and outside, break them into separate parts.

INTERIM LIFE SAFETY PLAN

ACKNOWLEDGMENT OF CONTRACTOR ILSM REVIEW

I have read and understand the Tulare Regional Medical Center ILSM Policy. I will ensure that all immediate employees assigned to the construction project in which I supervise will adhere to applicable policies, procedures, and safety standards in accordance with federal and local regulatory agencies that govern occupational safety practices

Contractor:

Signed: _____ Date: _____

Descriptive Name: Interim Life Safety Measures (ILSM)

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Forward To: Policy Binders (PBX and Administration) and Post to Intranet

Disposition: Copy and Distribution - Administration

Comments:

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		Dressings cover 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.
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 alchohol 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 (Notice to Readers: Occupational Health Guidelines for Remediation Workers at Bacillus anthracis-Contaminated Sites ---United Startes, 2001-2002) **Hand hygiene:** Handwashing for 30-60 seconds with soap and water or 2% chlorhexidene gluconate after spore contact (alcohol handrubs inactive against spores [983].

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			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 Clostridium difficile)			
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 [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 irritations required[154].
Avian influenza (see influenza, avian below)			
Babesiosis	Standard		Not transmitted from person to person except rarely by transfusion.
Blatomycosis, North Americn, 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	Contact + Standard	Duration of illness	Use mask according to Standard Precautions.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
children.			
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].
Campylobacter gastroenteritis (see gastroenteritis)			
Candidiasis, all forms including mucocutaneous	Standard		
Cat-scratch fever (benign inoculation lymphoreticulosis	Standard		Not transmitted from person to person.
Cellulitis	Standard		
Chancroid (soft chancre) *(H. ducreyi)*	Standard		Transmitted sexually from person to person.
Chickenpox (see >varicella)			
Chlamydia trachomatis Conjunctivitis	Standard		
Chlamydia trachomatis Genital (lymphogranuloma venereum)	Standard		
Chlamydia trachomatis Pneumonia (infants ≤ 3 mos. Of age)	Standard		
Chlamydia pneumoniae	Standard		Outbreaks in institutionalized populations reported, rarely [1051, 1052].
Cholera (see gastroenteritis)			
Closed-cavity infection Open drain in place; limited or minor drainage.	Standard		

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Clostridium botulinum	Standard		Not transmitted from person to person.
Clostridium difficile (see gastroenteritis, *C. difficile*)	Contact + Standard	Duration of illness	
Clostridium perfringens *Food poisoning*	Standard		Not transmitted from person to person
Clostridium perfringens *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 *Coccidioides immitis* 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 Coccidioides immitis 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.
Conjunctivitis Acute bacterial	Standard		
Conjunctivitis Acute bacterial Chlamydia	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

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			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)			
Creutzfelat-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.
Decubitis ulcer (see Pressure ulcer)			
Dengue fever	Standard		Not transmitted from person to person.
Diarrhea, acute-infective etiology suspected (see gastroenteritis)			
Diphtheria Cutaneous	Contract + Standard	Until off antimicrobial treatment and	Until 2 cultures taken 24 hours apart negative.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
		culture negative	
Diphtheria Pharyngeal	Droplet + Standard	Until off antimicrobial treatment and culture-negative	Until 2 cultures taken 24 hours apart negative
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/ accessed May 2016).
Echinococcosis (hydatidosis)	Standard		Not transmitted from person to person.
Echovirus (see enteroviral infection)			
Encephalitits or encephalomyelitis (see specific etiologic agents)			
Endometritis (endomyometritis)	Standard		
Enterobiasis (pinworm disease, oxyuriasis)	Standard		
Enterococcus species (see multidrug-resistant organisms if epidemiologically significant or vancomycin resistant)			
Enterocolitis, *C.difficile* (see *C. difficile*, 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	Droplet +	Until 24 hours	See specific disease agents for epiglottitis due to other

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Haemophilus influenzae type b	Standard	after initiation of effective therapy.	etiologies)
Epstein-Barr virus infection, including infectious mononucleosis	Standard		
Erythema infectiosum (also see Parvovirus B19)			
Escherichia coli gastroenteritis (see gastroenteritis)			
Food poisoning Botulism	Standard		Not transmitted from person to person
Food poisoning *C. perfringens or welchii*	Standard		Not transmitted from person to person
Food poisoning 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 *Campylobacter* species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Cholera (*Vibrio cholerae*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis	Contact +	Duration of	Discontinue antibiotics if appropriate. Do not share

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
C. difficile	Standard	illness	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 handrubs [983].
Gastroenteritis *Cryptosporidium* species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *E. Coli* 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 *E. Coli* Other species	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Giardia lamblia*	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Noroviruss	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 handrubs are not effective for hand decontamination [294]. Cohorting of affected patients to separate airspaces and toilet facilities may help interrupt transmission during outbreaks.
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].

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Gastroenteritis *Salmonella species* (including *S. tyohi*)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis *Shigella species* (Bacillary dysentery)	Standard		Use Contact Precautions for diapered or incontinent persons for the duration of illness or to control institutional outbreaks.
Gastroenteritis Vibrio parahaemolyticus	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 *Yersinia enterocolitics*	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)			
Giardis (see gastroenteritis)			
Gonococcal ophthalmia noeonatorum (gonorrheal ophthalmia, acute conjunctivits of newborn)	Standard		
Gonorrhea	Standard		
Granuloma inguinale (Donovanosis, granuloma venereum)	Standard		
Guillain-Barre' syndrome	Standard		Not an infectious condition.
Haemophilus influenzae (see disease-specific recommendations)			
Hand, foot, and mouth disease (see enteroviral infection)			
Hansen's Disease (see			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Leprosy)			
Hantavirus pulmonary syndrome	Standard		Not transmitted from person to person.
Helicobacter pylori	Standard		
Hepatitis, viral Type A	Standard		Provide hepatitis A vaccine post-exposure as recommended [1065].
Hepatitis, viral Type A- Dispered 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 [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		
Herpangia (see enteroviral infection)			
Hookworm	Standard		
Herpes simplex *(Herpesvirus hominis)* Encephalitis	Standard		
Herpes simplex (Herpesvirus hominis) Mucocutaneouos, disseminated or primary severe	Standard		

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Herpes simplex (Herpesvirus hominis) 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 ruptutred 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 immunocompromized 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 drainining)	HAI reported [1071], but route of transmission not established [832]. 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			See Prevention Strategies for Seasonal Influenza in

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Human (seasonal influenza)			Healthcare Settings [Current version of this document may differ from original.] 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 Viruses Associated with Severe Disease, accessed May 2016]. for current avian influenza guidance.
Influenza Pandemic Influenza (also a human influenza virus)	Droplet		See [This link is no longer active: https://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, accessed May 2016.] 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: https://www.cdc.gov/ncidod/dpd/parasites/lice/default.htm. Similar information may be found at CDC's Parasites – Lice. Accessed May 2016.}
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 Parasites – Lice.
Lice Pubic	Standard		Transmitted person to person through sexual contact See CDC's Parasites – Lice.
Listerosis (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	Standard		Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
chroriomeningitis			
Lymphogranuloma venereum	Standard		
Malaria	Standard		Not transmitted from person to person except through transfusion rarely and through a failure to follow Standard Precautions during outpatient care. [1076-1079] Install screens in windows and doors in endemic areas. Use DEET – containing mosquito repellants and clothing to cover extremities.
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	Measles [November 2011] ⚠ Update: Recommendations for healthcare workers can be found at Immunization of Healthcare Personnel; Recommendations of the Advisory Committee on Immunization Practice (ACIP) [PDF-705KB]. 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 susceptibles, 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.
Melioidosis, all forms	Standard		Not transmitted from person to person.
Meningitis Aseptic (nonbacterial or viral; also see enteroviral infections.	Standard		Contract for infants and young children.
Meningitis Bacterial, gram-negative enteric, in neonates.	Standard		
Meningitis Fungal	Standard		
Meningitis	Droplet +	Until 24 hours	

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Haemophilus Infuenzae, type b known or suspected.	Standard	after initiation of effective therapy.	
Meningitis *Listeria monocytogenes* (See Listerosis)	Standard		
Meningitis *Streptococcus penumoniae*	Standard		
Meningitis *M. tuberculosis*	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		
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].
Molluscum contagiosum	Standard		
Monkeypox	Airborne + Contact + Standard	Airborne – until monkeypox confirmed and smallpox excluded Contact-Until lesions crusted.	See CDC's Monkeypox website [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.
Mucormycosis	Standard		
Multidrug-resistant organisms (MDROs) infection or colonization (e.g. MRSA, VRE, VISA/VRSA. ESBLs, resistant *S. pneumonie*)	Contact + Standard	DS, Duration of entire length of stay	MDROs judged by the infection control program, based on local,s tate, 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

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			options in Management of Multidrug Resistant Organisms in Healthcare Settings. 2006 [870]. Contact state health department for guidance regarding new or emerging MDRO.
Mumps (infectious parotitis)	Droplet + Standard	Until 5 days	**Mumps [October 2017]** *Update on mumps recommendation* **Update:** The Healthcare Infection Control Practices Advisory Committee (HICPAC) voted to change the recommendation of isolation for persons with mumps from 9 days to 5 days based on this 2008 MMWR report. After onset of swelling, susceptible HCWs should not provide care if immune caregivers are available. **The below note has been superseded by the above recommendation update.** 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 (atypcial) Wound	Standard		
Mycoplasma pneumonia	Droplet+ Standard	Duration of illness	
Necrotizing enterocolitis	Standard		Contact Precautions when cases clustered temporarily [1080-1083].
Nocardiosis, draining lesions, or other presentations.	Standard		Not transmitted person-to-person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
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 antigentesting 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 persistent 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	Single patient room preferred. Cohorting option. Post-exposure chemoprophylaxis for household contacts and HCWs with prolonged exposure to respiratory secretions [863]. Recommendations for Tdap vaccine I adults under development. *Tdap vaccine recommendations [2011].* **Update:** Current recommendations can be found at Tdap/TdACIP Vaccine Recommendations.
Pinworm infection (Enterobiasis)	Standard		
Plague (*Yersinia pestis*) Bubonic	Standard		
Plague (*Yersinia Pestis*) Pneumonic	Droplet-Standard	Until 48 hours	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

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			prolonged shedding of virus. [931].
Pneumonia Bacterial not listed elsewhere (including gram-negative bacterial)	Standard		
Pneumonia *B. cepacia* 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 *B. cepacia* in patients without CF (see multidrug-resistant organisms)			
Pneumonia *Chlamydia*	Standard		
Pneumonia Fungal	Standard		
Pneumonia *Haemophillus influenzae*, type b Adults	Standard		
Pneumonia *Haemophillus influenzae*, type b Infants and children	Droplet + Standard	Until 24 hous after initiation of effective therapy	
Pneumonia Legionella spp.	Standard		
Pneumonia Meningococcal	Droplet + Standard	Until 24 hours after initiation of effective therapy	See meningococcal disease above.
Pneumonia Multidrug-resistant			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
bacterial (see multidrug-resistant organisms.			
Pneumonia *Mycoplasma* (primary atypical Pneumonia)	Droplet	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 *Pneumo Cystis jiroveci* *(Pneumocystis carinii)*	Standard		Avoid placement in the same room with an immunocompromised patient.
Pneumonia *Staphylococcus aureus*	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 Streptococcus, 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,			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
acute, or specific viral agent.)			
Poliomyelitis	Contact + Standard	Duration of illness (with wound lesions, until wounds stop draining)	
Pressure ulcer (decubitis 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 (decubitis ulcer, pressure sore) infected Minor or limited	Standard		If dressing covers and contains drainage.
Prior disease (See Creutzfeld-Jacob Disease)			
Psittacosis (ornithosis) *(Chlamydia psittaci)*	Standard		Not transmitted from person to person.
Q fever	Standard		
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 (Streptobacillus moniliformis disease, Spirillim minus 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	Standard		

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
covered elsewhere) Adults			
Respiratory infectious disease, (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 wound stops 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], rehabillitation 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 b HHV-6)	Standard		

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Rotavirus infection (see gastroenteritis)			
Rubella (German measles) (also see congenital rubella)	Droplet + Standard	Until 7 days after onset of rash	Susceptible HCWs should not enter room if immune caregivers are available. No recommendation for 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 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	
Scalded skin syndrome, staphylococcal	Cotnact	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 “supersheddres” 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]. Accessed May 2016.]
Shigellosis (see gastroenteritis)			
Smallpox (variola; see	Ariborne +	Duration of	Until all scabs have crusted and separated (3-4 weeks).

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia for management of vaccinated persons)	Contact + Standard	illness (with wound lesions, until wounds stop draining)	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		
Spirillum minor disease (rat-bite fever)	Standard		Not transmitted from person to person.
Staphylococcal disease *(S. aureus)* Skin, wound, or burn Major	Contact	Duration of illness (with wound lesions, until wound stops draining)	No dressing or dressing does not contain drainage adequately.
Staphylococcal disease *(S. aureus)* Skin, wound, or burn Minor or limited	Standard		Dressing covers and contains drainage adequately.
Staphylococcal disease *(S. aureus)* Enterocolitis	Standard		Use Contact Precautions for diapered or incontinent children for duration of illness.
Staphylococcal disease *(S. aureus)* Multidrug-resistant (see multidrug-resistant organisms)			
Staphylococcal disease (*S. aureus*) Pneumonia	Standard		
Staphylococcal disease (*S. aureus*) Scalded skin syndrome	Contact	Duration of illness (with wound lesions, until wounds stop draining)	Consider healthcare personnel as potential source of nursery, NICU outbreak [1095].
Staphylococcal disease (*S. aureus*) Toxic shock syndrome	Standard		
Streptobacillus moniliformis disease (rat-bite fever)	Standard		Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
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.
Streptococcal disease (group A streptococcus) Skin, wound, or burn Minor or limited	Standard		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	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Pneumonia	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Scarlet fever in infants and young children	Droplet	Until 24 hours after initiation of effective therapy	
Streptococcal disease (group A streptococcus) Serious invasive disease	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			

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
organisms)			
Strongyloidiasis	Standard		
Syphillis Latent (tertiary) and seropositivity without lesions	Standard		
Syphillis Skin and mucuos membrane, including congenital, primary. Secondary	Standard		
Tapeworm disease Hymenolepsis nana	Standard		Not transmitted from person to person.
Tapeworm disease Taenia solium (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 Creutzfela-Jacob disease CJD, vCJD)			
Trench mouth (Vincent's angina)	Standard		

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Trichinosis	Standard		
Trichomoniasis	Standard		
Trichuriasis (whipworm disease)	Standard		
Tuberculosis (M. tuberculosis) 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 (M. tuberculosis) 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 (M. tuberculosis) Pulmonary or laryngeal disease, confirmed.	Airborne		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 Mycobacterium tuberculosis in Health-Care Settings, 2005) [12].
Tuberculosis (M. tuberculosis) Pulmonary or laryngeal disease, suspected.	Airborne		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 specimens should be collected 8-24 hours apart, and at least one should be an early morning specimen.
Tuberculosis (M. tuberculosis) Skin-test positive with no evidence of current active disease	Standard		
Tuleremia Draining lesion	Standard		Not transmitted from person to person.
Tuleremia	Standard		Not transmitted from person to person.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Pulmonary			
Typhoid (Salmonella typhi) fever (see gastroenteritis)			
Typhus Rickettsia prowazekii (Epidemic or Louse-borne Typhus)	Standard		Transmitted from person to person through close personal or clothing contact.
Typhus Rickettsia typhi	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	Until lesions dry and crusted, scabs separated	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Fetal vaccinia	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	Until lesions dry and crusted, scabs	For contact with virus-containing lesions and exudative material.
Vaccinia (adverse events following vaccination) Progressive vaccinia	Contact		For contact with virus-containing lesions and exudative material.

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
Vaccinia (adverse events following vaccination) PostVaccinia encephalitis	Standard		
Vaccinia (adverse events following vaccination) Blepharitis or conjunctivitis	Contact + Standard		Use Contact Precautions if there is copious drainage.
Vaccinia (adverse events following vaccination) Iritis or keratitis	Standard		
Vaccinia (adverse events following vaccination) Vaccinia-associated erythema multiforme (Stevens Johnson Syndrome)	Standard		Not an infection condition.
Vaccinia (adverse events following vaccination) Secondary bacterial infection (e.g. *S. aureus*, 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, ie. 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, 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,

Infection/Condition	Type of Precaution	Duration of Precaution	Precautions/Comments
			regardless of postexposure vaccination. [1036]
Variola (see smallpox)			
Vibrio parahaemolyticus (see gastroenteritis)			
Vincent's angina (trench mouth)	Standard		
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses	Standard + Droplet + Contact	Duration of illness (with wound lesions, until wounds stop draining)	Single-patient room preferred. Emphasize: 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. Largest viral load in final stages of illness when hemorrage 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. Viral respiratory diseases (not covered elsewhere) Standard Adults
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.
Wound infections Minor or limited	Standard		Dressing covers and contains drainage adequately.
Yersinia enterocolitics Gastroenteritis (see gasroenteritis)			
Zoster (varicella-zoster) (see herpes zoster)	Standard		Not transmitted person-to-person.