

**PROVIDENCE LITTLE COMPANY OF MARY MEDICAL CENTER TORRANCE  
MEDICAL EXECUTIVE COMMITTEE**

**March 5, 2024  
Agenda Attachment**

Policies & Procedures:

Therapy Services: Scope of Service – Occupational Therapy  
Labeling Laboratory Specimens  
Brain Death Determination in the Adult Patient Population  
Women's and Children's: Standardized Procedures for Medical Screening Examination by L&D  
Registered Nurse  
Computerized Tube System (CTS)  
Employee Food and Drink in Patient Care Areas  
Pneumococcal Prevention and Control Plan  
POM: Ice Machine Care and Maintenance  
POM: Standard Precautions and Isolation Precautions  
Refrigerator/Freezer Logs  
Therapy Services: Physical Therapy Wound Care Evaluation and Treatment  
2024 Infection Prevention Program Plan  
2024 Infection Prevention Risk Assessment Program Effectiveness and Goals  
Availability of Patient Specific Information for Medical Management  
Drug Product Vendors' Representatives  
Herbal Remedies  
Parenteral Nutrition  
Clinical Dietetics: Nutrition Screening  
POM: Medication Refrigerator Temperature Monitoring

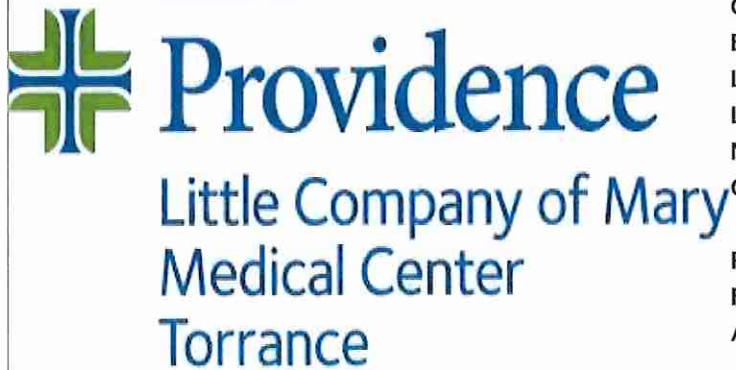
Privilege Forms:

Proposed Revision to Department of OBGYN Privilege Form:  
DaVinci Surgical Platform: *Revision of language to add "or eligibility" for board certification under Additional Criteria.*

Proposed Revision to Department of Surgery (Subsections) Privilege Form:  
Otolaryngology Privileges: *removal of the areas of procedures under qualifications for documentation of performance; revision of the percentage of number of cases to 20% from 25% that must be submitted from an acute care hospital for Appointment/Reappointment; addition and removal of procedures, number of cases needed every 24-months, and number of cases to be proctored under Special Procedure Privileges; revision to Otolaryngology Core Procedure List.*

General Surgery DaVinci Surgical Platform Privileges: *Revision of language to add "or eligibility" for board certification under Additional Criteria.*

Urology Surgery DaVinci Surgical Platform Privileges: *Revision of language to add "or eligibility" for board certification under Additional Criteria.*



Origination: 02/2021  
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Owner: Maria Aoki: Director  
Rehabilitation Services  
Policy Area: Therapy Services  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## Therapy Services: Scope of Service - Occupational Therapy Services

### POLICY

In keeping with the mission and values of Providence Health & Services, It is the Policy of Providence Little Company of Mary - Torrance (PLCMMCT) to provide Occupational Therapy in the Acute in-patient units, sub acute unit and outpatient clinic.

### PURPOSE

The purpose of the policy is to define Occupational Therapy services as part of a comprehensive Rehabilitation Services. The overall focus of Rehabilitation Services is to restore the individual to their fullest physical, mental, social, vocational and economic potential; to increase community awareness of various injuries, disorders and their prevention and treatment; to enhance the professional community's awareness of resource; to provide high quality therapy programs while maintaining cost-effective treatment, and to establish communication and mutual influence with members of the community regarding the functions of Rehabilitation Services

### PROCEDURE/GENERAL INSTRUCTIONS

#### 1. Practice

A. The practice of occupational therapy means the therapeutic use of occupations, including everyday life activities with individuals, groups, populations, or organizations to support participation, performance, and function in roles and situations in home, school, workplace, community, and other settings.

B. Occupational therapy services are provided for habilitation, rehabilitation, and the promotion of health condition, impairment, disability, activity limitation, or participation restriction.

C. Occupational therapy addresses the physical, cognitive, psychosocial, sensory-perceptual, and other aspects of performance in a variety of contexts and environments to support engagement in occupations that affect physical and mental health, well-being and quality of life.

#### 2. Patient care

A. Coordinate therapy programs with physicians and other allied health care team members.



B. Communicate the patient's status, potential and progress to physicians and other allied health care team members.

C. Recommend and provide durable medical equipment training to patient and family.

D. Participate with the health care team in discharge planning and follow-up

### 3. Administration

A. Develop personnel and operating budgets for the department.

B. Participate in the planning, development and implementation of hospital/department goals, objectives, policies and procedures.

C. Promote caregiver and leader development, training and engagement

### 4. Community Activities

A. Provide education to the community regarding Rehabilitation Services, particularly as related to wellness and prevention of injury and illness.

B. Participate in community outreach activities, thereby benefiting the community and furthering the mission of Providence St. Joseph Health.

### 5. Education

A. Provide in-service education for all levels.

B. Establish liaison relationships with various schools for therapy programs.

C. Provide clinical training programs for therapy students.

D. Assist in orienting students and other community members on health care specialties specifically regarding physical therapy, occupational therapy and speech and language pathology.

6. Age of patients served; 0-100+ and can be organized into the categories of neonates, infants, pediatrics, adolescents, young adults, adults and geriatrics.

7. Patient Services Delivered - After referral/order from a qualifying provider (MD, DO, NP, PA) has been received, an evaluation is performed. Occupational therapy evaluations provide baseline data from which to establish individual treatment programs. Based upon findings and patient's goals, occupational therapy goals are established and services provided.

A. Diagnostic screening and evaluation based on qualifying provider's order; General medical/orthopedic evaluation, neurological evaluation, lymphedema/oncology evaluation, feeding and positioning evaluation, hand evaluation, cognitive and perceptual evaluations, vision screening, developmental evaluation (for neonatal and pediatric population), sensory and sensory integration evaluations, home safety evaluations. Areas tested include: range of motion, strength, sensation, pain, activities of daily living (ADLs), cognitive, visual/visual-perceptual function, endurance, functional mobility, balance and coordination, sensory integration and psycho-social function.

B. Therapeutic: ADLs and self care retraining, training in functional activities/mobility, exercise programs, educational instruction/training, coordination and balance activities, endurance building tasks, splinting, feeding and positioning training, manual therapy including lymph drainage and bandaging and sensory integration.

C. Preventive: Education on joint protection, surgical precautions, work simplification, body mechanics; stress management and assertiveness training; instruction on positioning and use of adaptive aids; family and patient education of disability and home program; custom fabricated splints; lymphedema precautions and contraindications, environmental modification/adaptation and contracted services for orthotics and prosthetics.

#### 8. Conditions and Diagnosis Treated

A. Neurological - stroke, head injury, Parkinson's Disease, spinal cord injury, muscular dystrophy, multiple sclerosis, amyotrophic lateral sclerosis, developmental disability, altered mental status/dementia, developmental delay, Cerebral Palsy, brachial plexus injuries, autism and sensory integration dysfunction, feeding and movement, disorders in neonates and pediatrics.

B. Orthopedic - joint replacements, hand injury (see D), arthritis, multiple trauma, laminectomy, amputee, extremities injuries and repairs, back injuries and repairs.

C. General Medical/Surgical - cardiac conditions, diabetes, cancer, respiratory disease, debilitated functional status, AIDS (HIV), severe obesity and intervention radiology

D. Hand Injury - upper extremity fractures, tendon lacerations and repairs, nerve injury and repairs, cumulative trauma, amputation, complex regional pain syndrome, surgical (tendon and nerve repairs, joint replacements, muscle/tendon transfers, multiple trauma repair, etc.) arthritis, muscle strains/sprains, burns, contractures

E. Oncology - primary and secondary Lymphedema, pre and post surgical oncology diagnoses.

F. Prematurity, Respiratory Distress Syndrome, Congenital anomaly/deformity

9. Treatments or Activities Performed - Therapeutic activities are designed to assist individuals in adapting to their social and physical environment, given their functional capacity, through mastery of essential living tasks. Important activities include:

A. Education and retraining in daily living skills such as grooming and hygiene, dressing, eating meal preparation, functional mobility, object manipulation, and community involvement.

B. Therapeutic adaptations, such as ~~assistive~~adaptive equipment and physical environment designed to promote independence in the home environment.

C. Sensorimotor treatment for strengthening, endurance, range of motion, coordination, balance, and spontaneous function of upper extremity.

D. Therapeutic activities for memory, orientation, cognition integration, vision and perception.

E. Prevention and health promotion through planning for leisure, self management skills, socialization, energy conservative, fall prevention, body mechanics, and joint protection/positioning/precautions.

F. Care of the terminally ill through maintenance of independent living skills and meaningful activity.

G. Splinting to maintain functional anatomy, and to correct deformity and proper positioning.

H. Pre-vocational training to facilitate return to work or prior occupation, including work site analysis and ergonomics training.

I. Hand therapy to facilitate hand function.

J. Manual lymph drainage to decrease lymphedema and assist in promoting collateral lymph drainage and lymphatic decongestion



K. Feeding training to facilitate normal oral motor skills

L. Patient/family education to increase awareness and understanding of the patient's functional strengths and weaknesses/limitations.

M. Application of orthotic devices and patient training in independence with ADL's.

N. Home programs to increase continuity of therapy program.

O. Dyadic interaction to promote psychosocial skills.

P. Care of pulmonary patients to work on ADLs skills, activity tolerance and energy conservation

Q. Development intervention, positioning and sensory integration.

R. Center of Optimal Aging (COA) - assist patient and families understand how to safely plan and navigate any potential obstacles that may arise during the aging process.

#### 10. Types Practitioners Providing Care

A. Occupational Therapist: is defined as an individual who meets the minimum education requirements specified in Section 2570.6 and is licensed in the state of California, whose license is in good standing as determined by the California Board of Occupational Therapy.

B. Occupational therapy assistant: is defined as an individual who is certified by the board of occupational therapy and is in good standing as determined by the board.

C. The Rehabilitation Aide is trained within the medical center by licensed therapy staff to assist with occupational therapist and occupational therapist assistant in patient care and department upkeep.

#### 11. Evaluation Time Frames

A. Referrals will be assessed within 48 hours of receipt of the order with the exception of stroke patients, they will be assessed within 24 hours of receipt

B. Upon receipt of the order, the evaluation is initiated within 72 hours for TCC/TCU

C. Upon receipt of the order, the evaluation is initiated within 72 hours for neonatal intensive care unit patients.

#### 12. Sites where Care is Provided

A. Occupational Therapy is provided within the Medical Center in acute inpatient units, including Neonatal Intensive Care Unit (NICU); with the Outpatient Clinic and within the Sub-acute unit

#### 13. Services are available/provided

A. Inpatient (acute, subacute, NICU) 8:00 a.m to 5:00 p.m. Monday - Sunday

B. Outpatient: 8:00 a.m. - 4:30 p.m. Monday - Friday

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	02/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	02/2024
Policy Committee	Maria Aoki: Director Rehabilitation Services	02/2024

## Applicability

CA - Providence LCM MC Torrance

COPY





# Providence

## Little Company of Mary Medical Center Torrance

Origination: 10/2004  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 07/2018  
Next Review: 3 years after approval  
Owner: Lalaine Berube: Senior Director  
Clinical Laboratory  
Policy Area: Patient Care Services  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Labeling Laboratory Specimens

### PURPOSE:

Proper identification of laboratory specimens by correct labeling is crucial for assuring accurate test results for the right patient. Certain collection information is also necessary for insuring fresh specimens that are within the defined time limits for testing, and for recording the identity of the collector in case communication regarding the specimen is required for problem solving. Hospital and Laboratory regulatory organizations require this information to be on all specimens submitted to the Laboratory.

### LABELING PROCEDURE:

- I. All specimens must be labeled by the collector.
  - A. All specimens must be labeled in the room (*at the patient's bedside*) in which they are collected before leaving the patient.
  - B. In emergent situations, it is acceptable for another person to label the specimens provided all the specimens are labeled in the room in which they are collected.
- II. All labels should be checked against the patient's ID wristband and the order requisition.
  - A. The label can be a barcode label or a patient label. It must have the patient's first and last name, date of birth and/or Medical Record number.
  - B. In checking the patient's ID wristband, it is critical to check TWO (2) patient identifiers, the name (*first and last name*) as well as the date of birth and/or Medical Record number.
- III. If a barcode or patient label is not available, the handwritten label must have the following: (*Use ballpoint, non-erasable pen*)
  - A. The patient's last name, first name and middle initial (*if available*).
  - B. The date of birth or medical record number.
  - C. The date and time of collection, and the lab tech code of the collector.
  - D. If the specimen is collected by registry staff without an issued lab tech code, the collector should include their initials instead.
- IV. Procedure:
  - A. After the specimen has been collected, affix the barcode or addressograph label on the tube/

container.

**B. Write the following information on the label:**

1. Time the specimen was collected
2. Date of collection
3. The lab tech code of the collector
4. If the specimen is collected by registry staff without an issued lab tech code, the collector **MUST** include their initials instead.

**V. Placement of labels on the specimen tube/container.**

- A. Place labels vertically down on all specimens/containers with the name of patient closest to the top of the tube. **Do NOT place label over the tube cap.** Affix the label on the manufacturer's pre-printed label leaving a visible space to see specimen volume.
  1. For microtainer tube specimens (*bullets*), labels may be placed horizontally making sure that the patient's name and/or Medical record number is visible.
  2. For blood culture bottles, place the labels vertically down making sure not to cover the pre-existing barcode label on the blood culture bottle itself.
  3. For urine specimens, labels may be placed horizontally on the container.
- B. Labels must be applied smoothly on the tubes/containers, with no wrinkles so that the laboratory instruments' barcode readers can read them.
- C. Place patient's specimen(s) in a single Biohazard bag, DO NOT put multiple patients in a single Biohazard bag.

**VI. Blood Bank has special requirements which are listed below:**

- A. Blood Bank specimens may be labeled with the barcode labels provided the full name and Medical Record number of the patient is legible.
- B. **Date of birth is NOT to be used as an identification field for Blood Bank specimens.**
- C. If a handwritten label is to be used, all information must be legibly handwritten in non-erasable ink using a ball point pen. The following information is to be written on the label:
  1. The patient's last name, first name and middle initial if available.
  2. The medical record number.
  3. The date and time of collection.
  4. The lab tech code of the collector.
  5. If the specimen is collected by registry staff without an issued lab tech code, the collector **MUST** include their initials instead.
- D. Blood Bank may require a separate draw to confirm the patient's blood type.

**VII. In the event that a patient is seen in the Emergency Department before the identification of the patient can be established:**

- A. The specimens must be labeled with "*Doe, John/Jane*" and the medical record number that is issued to the patient at the time the patient is registered as John/Jane Doe.
- B. Include date and time of collection and lab tech code or initials of the collector.



- C. If the specimen is collected by registry staff without an issued lab tech code, the collector **MUST** include their initials instead.

**VIII. For downtime procedures, i.e. HIS is not available to register patients, specimen labels must include:**

- A. Patient's last name, first name, middle initial (*if available*).
- B. Date of birth
- C. Medical Record number if available. If the Medical Record number is not available, the account number may be used if it is available.
- D. Date and time of collection
- E. Lab Tech code of collector.
- F. If the specimen is collected by registry staff without an issued lab tech code, the collector **MUST** include their initials instead.

**IX. All specimens must be placed in Biohazard bags for transport to the Laboratory.**

- A. Lids on containers such as urine specimens should be securely closed to prevent leakage during transport.
- B. Specimens of different types (*i.e. urine, saliva, blood*) **MUST** not be placed in the same biohazard bag. It is permissible to group "like" samples from the same patient into the same bag (*i.e. blood and blood*). If leakage occurs between differing samples, both specimens will have to be recollected.
- C. Do not put the lab requisition and the specimen in the same pocket of the Biohazard bag as in the event of specimen leakage the lab requisition may be soiled.

## PROCEDURAL NOTES:

- I. All patients must be identified by the use of the hospital issued ID wristband.
- II. Do not pre-label specimen tubes or containers before the specimen is collected.
- III. Label the specimen tube/container immediately after collecting the specimen and in the presence of the patient. This reassures the patient that their specimen is labeled correctly.

## REFERENCE:

- Stockbower, Jean; Procedures for the Collection of Diagnostic Blood Specimens by Venipuncture; National Committee for Clinical Standards, Document H3-A3, Vol. 11, No. 10; Villanova, Pa., 1991.
- The Joint Commission
- Document Central Policy Number: LCM-PC-312

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
CNO	Scott Ciesielski: Chief Nursing Officer	02/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	02/2024
Policy Committee	Lalaine Berube: Senior Director Clinical Laboratory	02/2024

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

COPY





# Providence

Little Company of Mary  
Medical Center  
Torrance

Origination: 12/1993  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 11/2023  
Next Review: 1 year after approval  
Owner: Catrice Nakamura: Executive  
Director Nursing  
Policy Area: Patient Rights & Ethics  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Brain Death Determination in the Adult Patient Population

### PURPOSE

The purpose of this policy is to define standards for the determination of death by neurological criteria, also known as "brain death", in adult patients (defined as those 18 years of age and older for purposes of this policy) in accordance with institutional, state and federal requirements.

### POLICY

State and Federal law require that a declaration of death be made in accordance with usual and customary standards of medical practice. The Uniform Determination of Death Act of the California Health and Safety Code Section 7180 - 7184.5 states:

- A. An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all function of the entire brain, including the brain stem is dead. (Section 7181)
- B. When an individual is pronounced dead by determining that the individual has sustained an irreversible cessation of all functions of the entire brain, including the brain stem, there shall be independent confirmation by another physician. (Section 7182)
- C. Neither physician making the neurologic confirmation of death shall participate in the procedures for removing or transplanting a body part from the deceased

This policy sets forth the Providence Little company of Mary Torrance and San Pedro (PLCMT and SP) guidelines for the determination of death by neurological criteria.

### DEFINITION(S)

- A. Death by neurological criteria is defined as the irreversible loss of the capacity for consciousness combined with the irreversible loss of all brain and brainstem functions, including the capacity to breathe. Death determined by neurological criteria is equivalent to the death of the individual, even though the heart continues to beat and spinal cord functions may persist.
- B. Attending: licensed physician that is participating in the overall care of the patient and cannot be classified as a Resident.

# PROCEDURE/GENERAL INSTRUCTIONS

## A. Procedure for the Declaration of Death based on Neurological Criteria:

- a. Two (2) licensed attending Board eligible/ certified physicians in the state of California with appropriate expertise for determination of death by neurological criteria are required to determine and document that a patient has suffered a total and irreversible cessation of all brain function.
- b. One (1) of the physicians must be a ~~Neurointensivist for Torrance and~~ Neurologist ~~for San Pedro~~.
- c. Neither physician can be involved in the subsequent anatomical donation process or surgery.
- d. Both physicians must adhere to the protocol set forth in this policy when evaluating a patient (see Steps for Brain Death Determination section for more details). The following criteria are used to declare brain death:
  - i. An etiology of coma that is capable of causing irreversible and total loss of brain and brainstem function are excluded or corrected.
  - ii. Any excluding confounding conditions that may depress or otherwise limit assessment of neurological function are excluded or corrected. \*See section C part a.iii labeled Steps for Brain Death Determination for list of potential confounding conditions
  - iii. Clinical examination has revealed no evidence of responsiveness (coma) and brainstem reflexes are absent.
  - iv. Apnea testing has shown no evidence of spontaneous breathing during an adequate CO2 challenge therefore only one (1) apnea test is required to be performed by either physician performing brain death assessment. See [Apnea Test for Brain Death Determination policy](#).
  - v. If indicated, ancillary testing has been performed and the results show no evidence of cerebral electrical activity or cerebral blood flow.
    1. Only one (1) ancillary test needs to be performed when indicated.

## B. Physician qualifications

- a. Two California licensed attending physicians who are credentialed and granted privileges to declare death by neurological criteria.
- b. One of the two physicians must be a ~~Neurointensivist for Torrance and~~ Neurologist ~~for San Pedro~~.
- c. Credentialing process to be renewed every 5 years:
  - i. Obtain certification after completing the Neurocritical Care Society Brain Death Determination Online Course (<https://www.neurocriticalcare.org/education/braindeath>).
  - ii. Review Determination of Brain Death Policy

## C. Steps for Brain Death Determination

- a. Prerequisites - Establish the cause and irreversibility of coma
  - i. History, examination, imaging, and laboratory studies are reviewed.



ii. An etiology of coma that is capable of causing irreversible and total loss of brain and brainstem function is established.

iii. Any confounding conditions that may depress or otherwise limit assessment of neurological function are excluded or corrected. Such conditions include:

1. Hypothermia (temperature less than 36 degrees Celsius or its equivalent).
2. Hypotension, defined as systolic blood pressure <100 mmHg.
3. Severe electrolyte disturbance.
4. Treatable metabolic disorders (including acid-base disorders, hepatic or renal encephalopathy, endocrine dysfunction, hyperammonemia and severe hyperosmolar states).
5. Drug intoxication or effects (particularly narcotics, barbiturates, sedatives and hypnotics).
6. Presence of neuromuscular blocking agents.

iv. If a confounder cannot be excluded or corrected, then an ancillary test must be performed.

b. Clinical Examination - Demonstrates complete loss of all brain and brainstem function through clinical examination (neurological exam).

i. Coma

1. The patient should be observed for spontaneous movement and response to noxious stimuli applied cranially and peripherally. There must be no brain-mediated responses, (including decorticate or decerebrate posturing, dyskinesias, myoclonus or seizures) spontaneously or in response to noxious stimuli.
2. Since the spinal cord may be intact, some reflex responses may be present, including deep tendon reflexes, plantar reflexes, triple flexion of the legs, toe flexion or extension on plantar stimulation, superficial abdominal reflexes, and reaction of the blood pressure to noxious stimulation. Complex motor movements "Lazarus sign" may also be observed, and require clinical expertise and/or ancillary testing to exclude cerebral origin.

ii. Brainstem reflexes are absent:

1. The pupils must be mid-size or larger and non-reactive to bright light. Care should be taken that atropine or related drugs have not been given. Small pupils should also alert the clinician to the possibility of drug effect.
2. If testing is not contraindicated eg. due to cervical spine injury, oculoccephalic "dolls eye" and oculovestibular (ice water caloric) responses must be absent.
3. During caloric stimulation, the head should be at 30 degrees above the horizontal, and the integrity of the tympanic membrane and patency of the ear canal ensured. Sixty (60) seconds of constant exposure to ice water in each ear should be applied. Both ears should be tested separately, with a five (5) minute period before testing the contralateral ear.
4. Corneal and pharyngeal (gag) reflexes must be absent.
5. No cough response to deep bronchial suctioning.
6. No movement of the head, face, or eyes in response to painful stimulation.
7. No spontaneous respirations.

iii. If any portion of the neurological examination cannot be completed, then an ancillary test must be performed.

c. Apnea Testing - Demonstrates the lack of spontaneous respiratory drive (apnea) in response to hypercapnea and respiratory acidosis.

See [Apnea Test for Brain Death Determination](#) policy.

d. **Ancillary Testing** if applicable - Demonstrates no evidence of cerebral electrical activity or cerebral blood flow ONLY when the clinical evaluation cannot be completed or reliably interpreted.

i. Indications

1. A confounding condition is present and can not be corrected
2. A portion of the clinical exam cannot be completed
3. Uncertainty exists about the reliability of the exam
4. Apnea testing cannot be completed

ii. Acceptable ancillary tests include :

1. Nuclear Medicine Cerebral Blood Flow Study (SPECT)

- a. The isotope should be injected within 30 minutes after its reconstitution
- b. Anterior and both lateral planar image counts (500,000) of the head should be obtained at several time points: immediately, between 30 and 60 minutes later, and at 2 hours
- c. A correct IV injection may be confirmed with additional images of the liver demonstrating uptake (optional)
- d. No radionuclide localization in the middle cerebral artery, anterior cerebral artery, or basilar artery territories of the cerebral hemispheres (hollow skull phenomenon)
- e. No tracer in superior sagittal sinus (minimal tracer can come from the scalp)

2. Catheter-based conventional cerebral angiography

- a. The contrast medium should be injected in the aortic arch under high pressure and reach both anterior and posterior circulations.
- b. No intracerebral filling should be detected at the level of entry of the carotid or vertebral artery to the skull.
- c. The external carotid circulation should be patent

3. Transcranial doppler ultrasonography (TCD)

- a. TCD is useful only if a reliable signal is found. The abnormalities should include either reverberating flow or small systolic peaks in early systole. A finding of a complete absence of flow may not be reliable owing to inadequate transtemporal windows for insonation. There should be bilateral insonation and anterior and posterior insonation. The probe should be placed at the temporal bone, above the zygomatic arch and the vertebrobasilar arteries, through the suboccipital transcranial window.
- b. Insonation through the orbital window can be considered to obtain a reliable signal. TCD may be less reliable in patients with prior craniotomy.

4. Electroencephalography



- a. A minimum of 8 scalp electrodes are to be used.
- b. Inter electrode impedance goal is between 100 and 10,000 ohms
- c. The integrity of the entire recording system should be tested
- d. The distance between electrodes are to be at least 10 cm
- e. The sensitivity is to be increased to at least 2 mV for 30 minutes with inclusion of appropriate calibrations.
- f. The high-frequency filter is not to be set below 30 Hz and the low-frequency setting should not be above 1 Hz.
- g. Electroencephalography is to demonstrate a lack of reactivity to intense somatosensory or audiovisual stimuli

## D. Documentation

- a. Each physician is required to document all findings in the EMR using the established documentation criteria.
- b. The official time of death can be considered one of the following:
  - i. The time the arterial blood gas is reported for the apnea test
  - ii. The time the physician officially signs the ancillary test
  - iii. The time the attending physician completes the second clinical examination.
- c. Communication
  - i. Patient next of kin is to be informed that a clinical evaluation of brain death is taking place
  - ii. Once a determination of clinical brain death has occurred the patient's next of kin is to be notified that the patient is legally dead.
  - iii. A reasonable amount of time up to 24 hours may be allowed before the ventilator may be removed from the patient. This is to allow time for family visitation and to support the grieving process. No further escalation of care will be offered during this waiting period including but not limited to lab draws, titration of pressors, and changes to ventilation and oxygen settings. This also includes no further dialysis for patients who have been receiving dialysis. \*Consideration is to be given to patients and their families with specific religious and cultural beliefs regarding brain death and end-of-life care. The bioethics committee and spiritual care team can be consulted for any support that may be needed during this time and when making these decisions.
  - iv. Consent from patient next of kin is not required to remove a ventilator from a patient once the patient has been deemed clinically brain dead.

## REFERENCE(S) / RELATED POLICIES

- [Lewis, A., Kirschen, M., Greer, D., \(2023\). The 2023 AAN/AAP/CNS/SCCM Pediatric and Adult Brain Death/Death by Neurologic Criteria Consensus Practice Guideline: A Comparison With the 2010 and 2011 Guidelines. Neurol Clin Pract Dec 2023, 13 \(6\) e200189; DOI: 10.1212/CPJ.0000000000200189](#)
- Neurocritical Care Society. Brain death toolkit-Neurocritical Care Society (2019). Retrieved from <https://www.neurocriticalcare.org/brain-death-toolkit>
- Neurocritical Care Society. Brain death policy Checklist-Neurocritical Care Society (2019). Retrieved from



<https://www.neurocriticalcare.org/brain-death-toolkit>

- California Health & Safety Code Section 7180-84: Neurological Determination of Death (Brain Death)
- Wijdicks, E. F, Varela, Panayiotis, Gronseth, G. & Greer, D. ( 2010). Evidence-Based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*, 74, 1911-1918
- Update: Determining Brain Death in Adults: AAN Summary of Evidence-Based Guideline for Clinicians (2010) *Neurology*, 74, 1911-1918
- Document Central Policy: LCT-RI-206

## Attachments

[New BD Template.pdf](#)

## Approval Signatures

Step Description	Approver	Date
MEC	Mayra Graves: Medical Staff Coordinator	pending
MEC	Denise Eastburn: Director Medical Staff Services	pending
Cardiology-T, Critical Care-T, Medicine(both)	Mayra Graves: Medical Staff Coordinator [TA]	02/2024
Cardiology-T, Critical Care-T, Medicine(both)	Mary Guglielmo: Associate Continuing Medical Education Coordinator [DE]	01/2024
Bioethics	Jennifer Kozakowski: Chief Mission Officer Ministry	11/2023
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023
Policy Committee	Catrice Nakamura: Executive Director Nursing	11/2023

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

<b>I. PREREQUISITES</b>	<b>FIRST EXAM</b>	<b>SECOND EXAM</b>
1. Clinical or neuroimaging evidence of acute CNS catastrophe that is compatible with irreversible loss of brain function	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Absence of severe electrolyte, acid base or endocrine disturbance or severe hyperammonemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Absence of drug intoxication, poisoning, sedatives or neuromuscular blocking agents	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Core temperature 96.8°F / 36°C or greater	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>II. COMA or UNRESPONSIVENESS</b>	<b>FIRST EXAM</b>	<b>SECOND EXAM</b>
Absence of any cerebrally-mediated response to auditory and tactile noxious stimulation, peripherally and in the cranium	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>III. ABSENCE of BRAINSTEM REFLEXES</b>	<b>FIRST EXAM</b>	<b>SECOND EXAM</b>
1. Pupillary size midposition or dilated	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
2. Pupils unresponsive to bright light	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
3. Absent oculoccephalic reflex	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
4. Absent oculovestibular reflex (caloric responses) (N.B. The oculovestibular reflex must always be tested. The oculoccephalic test may be contraindicated when C-spine integrity questioned; otherwise it must be tested.)	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
5. Absent corneal reflexes	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
6. Absent response to posterior pharyngeal stimulation	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
7. Absent cough to bronchial suctioning	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Untestable <input type="checkbox"/>
8. Absent spontaneous respirations	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>IV APNEA TEST</b>
----------------------

<p>A. Prerequisites</p> <ol style="list-style-type: none"> <li>1. Core temperature 96.8° F/ 36° C or greater</li> <li>2. Systolic BP &gt; 100 mmHg (with or without vasopressor agents)</li> <li>3. Arterial pCO<sub>2</sub> 40 +/- 5 mm Hg (in known non-CO<sub>2</sub> retainer)</li> <li>4. Arterial pO<sub>2</sub> greater than 90 mm Hg</li> </ol> <p>B. Apnea testing checklist</p> <ol style="list-style-type: none"> <li>1. Preoxygenate to a PaO<sub>2</sub> &gt;200 mm Hg and then administer 100% FIO<sub>2</sub> during the entire test period</li> <li>2. Disconnect the ventilator; monitor with pulse oximeter throughout the test period</li> <li>3. Deliver 100% FIO<sub>2</sub> into the trachea via a cannula at the level of the carina, maintaining oxygen saturation above 85%</li> <li>4. Check arterial blood gases at 8-10 minutes and reconnect the ventilator when either <ol style="list-style-type: none"> <li>a) pCO<sub>2</sub> is 60 mmHg or greater, or b) pCO<sub>2</sub> is greater than 20 mmHg above the patient's known baseline (in known CO<sub>2</sub> retainers)</li> </ol> </li> <li>5. Abort the apnea test and immediately reconnect the ventilator for any of the following reasons: <ol style="list-style-type: none"> <li>a. Systolic BP falls below 90 mm Hg or there is cardiovascular collapse</li> <li>b. Oxygen desaturation (&lt;85% for &gt;30 seconds)</li> <li>c. Significant cardiac arrhythmia</li> <li>d. Respiratory movements are observed</li> </ol> </li> </ol>	<p>APNEA CONFIRMED Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>OR</p> <p>APNEA TESTING CONTRAINDICATED Yes <input type="checkbox"/></p> <p>OR</p> <p>APNEA TEST ABORTED Yes <input type="checkbox"/></p>	<p>REPEAT APNEA TESTING IS NOT REQUIRED IF THE FIRST TEST CONFIRMS APNEA</p>
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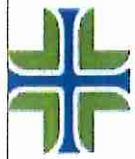
<p><b>V. ANCILLARY TESTING IS REQUIRED WHEN ITEMS I AND II ARE MET BUT EITHER ITEM III (BRAINSTEM REFLEX TESTING) OR ITEM IV (APNEA TESTING) CANNOT BE COMPLETED OR CONFIDENTLY INTERPRETED</b></p>		
<input type="checkbox"/> CONVENTIONAL CATHETER-BASED CEREBRAL ANGIOGRAPH		
<input type="checkbox"/> NUCLEAR MEDICINE CEREBRAL BLOOD FLOW STUDY (TECHNETIUM 99M SPECT)		
<input type="checkbox"/> TRANSCRANIAL DOPPLER		
<input type="checkbox"/> ELECTROENCEPHALOGRAPHY		
DEMONSTRATED ABSENCE OF CEREBRAL BLOOD FLOW OR CEREBRAL ELECTRICAL ACTIVITY: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<input type="checkbox"/> Computed tomography angiography (CTA)		
<b>SUMMARY OF FINDINGS</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
I PREREQUISITES	Yes <input type="checkbox"/> No <input type="checkbox"/>	
II COMA or UNRESPONSIVENESS	Yes <input type="checkbox"/> No <input type="checkbox"/>	
III ABSENCE of BRAINSTEM REFLEXES	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> untestable
IV APNEA	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> aborted or contraindicated
V BRAIN DEATH ESTABLISHED BY ANCILLARY TESTING	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> not indicated
CONFIRMED DEATH IN ADULTS BY Neurological CRITERIA	Yes <input type="checkbox"/> No <input type="checkbox"/>	

	Date	Time
1st examiner signature		
2nd examiner signature		



Current Status: Pending

PolicyStat ID: 14865829



Providence

Little Company of Mary  
Medical Center  
Torrance

Origination: 01/2001  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 09/2022  
Next Review: 1 year after approval  
Owner: Lisa Yauchzee-Gac: Executive  
Director Nursing  
Policy Area: Women's Services  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## Women's and Children's: Standardized Procedure for Medical Screening Examination by L&D Registered Nurse

### PURPOSE:

The purpose of this policy is to:

1. Define the circumstances under and the process by which a Registered Nurse (RN) competent in Labor and Delivery (L&D) may perform a medical screening examination to determine if a patient is in labor.
2. Identify the means by which L&D RNs are deemed competent to perform medical screening examinations to determine if a patient is in labor..

### RESPONSIBILITY:

Obstetrician, Labor and Delivery competent RN

### DEFINITIONS:

**Medical Screening Examination:** the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist (*Interpretive Guidelines, Public Health and Welfare Code Subpart B 489.24*)

**Emergency Medical Condition:** a medical condition manifesting itself by acute symptoms of sufficient severity (*including severe pain*) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (*or, with respect to a pregnant woman, the health of the woman or her unborn child*) in serious jeopardy.
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- With respect to a pregnant woman who is having contractions.
- When there is inadequate time to ensure a safe transfer to another hospital before delivery; or
- The transfer may pose a threat to the health or safety of the woman or the unborn child [*Public Health and Welfare Code 42 1395dd(e)(1)*]

**Labor:** the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a Physician, Certified Nurse Midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor. [Public Health and Welfare Code Subpart B 489.24(b)]

## POLICY:

1. Under the Emergency Medical Treatment and Labor Act (EMTALA), it is presumed that a woman having contractions is in labor, unless a Physician, after a reasonable period of observation, certifies that the woman is in false labor. A woman in early labor may be discharged if it is safe to do so, with instructions to return to the hospital or to another available facility when the contractions are closer together.
2. Circumstances under which a L&D RN deemed competent in performing a medical screening examination may do so:
  - A. Setting: In the Women's Health Unit and the Emergency Department
  - B. Scope of Supervision
    - Direct supervision by a physician is not required during the procedure.
    - A RN who is deemed competent in the procedure may perform a medical screening examination in the Women's Health Unit to determine if a patient is in labor. The RN will contact the patient's Obstetrician or the Obstetrician on call, as appropriate, to discuss the scope and results of the assessment. The Physician will determine whether the patient will be admitted, transferred or discharged, and will provide medical orders/management to ensure appropriate continuity of care. These orders may be entered into the patient's Electronic Health Record (EHR) remotely by the Physician, or may be telephone orders. A Physician must always be contacted prior to a patient's release from the hospital.
  - C. Patient conditions: A medical screening examination will be performed on every pregnant patient greater than or equal to 20 weeks' gestation who presents to the Women's Health Unit or Emergency Department (as needed for Torrance) for assessment.
3. Requirements for RN
  - A. Initial demonstration of competence: A RN must meet the following requirements to be deemed competent to perform medical screening examinations in the Women's Health Unit without supervision:
    - Permanent employment by Providence Little Company of Mary Medical Center (PLCMMC) or status as a long term and/or pre-assigned supplemental staff member ("*traveler*" or *pre-assigned registry staff member*). Shift to shift supplemental staff members or shift to shift registry nurses may not perform medical screening examinations.
    - Successful completion of orientation to L&D care in a PLCMMC facility and the Women's Health Orientation Checklist.
    - Demonstrated competence in the performance of vaginal examinations of pregnant patients to include dilatation and effacement of the cervix, status of the membranes and identification, position, and station of the presenting part.
    - Demonstrated competence in the detection of amniotic fluid by Point of Care (POC) testing.
    - Demonstrated competence in the performance of sterile speculum examinations of pregnant



patients, including observation of the cervix for leakage of amniotic fluid.

- Successful completion of a course or courses in fetal monitoring, including fetal heart and uterine physiology, recognition of fetal heart rate (FHR) and uterine contraction patterns, FHR variability, nursing interventions in response to FHR/uterine contraction monitoring and use of National Institute of Child Health and Human Development (NICHD) terminology.
  - Demonstrated competence in the performance of a medical screening examination as defined in this policy and procedure, supervised by a designated evaluator, and documented on the Medical Screening Examination by L&D Competent Registered Nurse competency checklist. A designated evaluator may be an Obstetrician on staff with PLCMMC or a RN deemed competent in the procedure.
- B. Continued demonstration of competence: In order to continue performing medical screening examinations in the Women's Health Unit at PLCMMC after completing initial competency, the RN must demonstrate continuing competency in the required skills listed in the job description and related policies and procedures. This is evaluated annually and documented in Healthstream.
4. A record of RNs authorized to perform medical screening examinations in the Women's Health Unit is maintained on the unit and in the Nursing Administration Office. The names of RNs who have recently been deemed competent to perform these examinations are presented to the members of the Department of Obstetrics and Gynecology at least annually during the regularly scheduled department meetings for approval as Qualified Medical Professionals (QMPs) able to perform medical screening examinations in the Women's Health Unit. The list of L&D competent RNs authorized to perform medical screening examinations is ultimately reported to the Governing Board for approval as QMP. RNs who have met the criteria for performing medical screening examinations in the Women's Health Unit and who have been deemed competent may perform these examinations without supervision pending their approval by the Department of Obstetrics and Gynecology. This standardized procedure is reviewed annually by the Director of Women's and Children's Health, by the chairperson of the Department of Obstetrics/ Gynecology and by the Interdisciplinary Practice Committee.
5. Direct (*in-person*) evaluation of the patient by a Physician is indicated in the following circumstances:
- A. Acute and/or continuing decompensation of the patient and/or fetus
  - B. Patient requiring transfer to a higher level of care for maternal and/or fetal indications
  - C. Patient history and/or laboratory findings inconsistent with clinical assessment
  - D. Positive result from a rapid HIV test performed in L&D
  - E. Identification of high-risk factors, including but not limited to:
    - Suspected fetal demise
    - Vaginal bleeding greater than bloody show and/or documented abnormal placentation
    - Preterm contractions or other signs/symptoms consistent with preterm labor not resolving as anticipated
    - Laboring patient with abnormal fetal lie; breech, brow or face presentation; maternal and/or fetal conditions which affect the ability of the patient and/or fetus to tolerate labor; febrile illness or other suspected infectious condition
    - Suspected preeclampsia, eclampsia and/or HELLP (hemolysis, elevated liver enzymes, low platelet count) syndrome



- Unexplained severe abdominal pain; severe headache; severe edema, especially of non-dependent tissues; and/or visual changes such as blurred, tunnel or double vision or spots before the eyes
- F. Problems not resolving as anticipated
- G. Upon request of the patient or RN
- 6. If the obstetrician determines from the information provided by the medical screening examination by the L&D competent RN that the patient does not have an obstetric emergency medical condition and that she requires a medical screening examination for a non-obstetric condition, the patient will be transferred to the Emergency Department upon the order of the Obstetrician.
- 7. A medical screening examination will be performed with pregnant patients who present to the Women's Health Unit for assessment prior to any inquiry about the patient's payment status.

## PROCEDURE:

1. As soon as a patient presents to the Women's Health Unit, greet her, and obtain the following information in order to prioritize, based on medical necessity, the order in which patients will receive further assessment:
  - Demographic data: Patient's name, birthdate, gravidity, and parity, estimated gestational age and/or EDC, if known
  - The reason the patient came to the Women's Health Unit (*presenting problem, chief complaint*)
  - If the patient is experiencing uterine contractions
  - If the patient is possibly preterm, if she is experiencing any other symptoms associated with preterm labor (*abdominal pain or cramping, low back pain, vaginal discharge, etc.*)
  - If the fetus is moving and active, or the last time movement was felt
  - Whether or not the patient is having any vaginal bleeding, and a description of the bleeding, if present
  - If the patient is experiencing high risk symptoms such as severe headache, blurred or tunnel vision, epigastric pain and/or edema of non-dependent tissues
  - If the patient is leaking fluid from the vagina, and a description of the fluid, if present
2. Enter or delegate another staff member to enter the patient's name, arrival time, and any other available information into the Patient Log. (*See "Patient Log [Central Log]" policy and procedure.*)
3. Review the patient's prenatal record, if available, and the information obtained in Step #1 to identify any urgent needs requiring priority assessment and to determine the initial eligibility of the patient for a medical screening examination by the RN. Contact the Obstetrician's office to obtain copies of any laboratory reports not available in the EHR or consult with Obstetrician for orders to test the patient.
4. Perform the medical screening examination. This examination is performed prior to any inquiry by a PLCMMC employee regarding the patient's payment status, and is to include:
  - Patient chief concern
  - A complete set of vital signs
  - Assessment of level of pain using pain scale 0 to 10
  - FHR via doppler or continuous electronic fetal monitor

- Uterine activity via palpation or tocodynamometer
  - Review of prenatal and health history including history of any mental health conditions or depression
  - Urine dipstick for protein
  - Vaginal examination (VE) (*upon admission or as ordered by Physician, unless contraindicated*) to include assessment of dilatation, effacement, station, presenting part, position of presenting part when possible, and status of membranes
  - POC testing of vaginal fluid if rupture of membranes is suspected
  - Sterile speculum examination
    - a. For collection of a specimen for fetal fibronectin enzyme immunoassay for eligible patients
    - b. If ordered by Obstetrician when necessary to obtain specimens for culture, and to evaluate for cervical dilatation, vaginal pooling and/or bleeding
    - c. To obtain specimens for fern testing and POC testing, when necessary, for patients suspected of having premature rupture of membranes (PROM) but whose POC testing for rupture of membranes (ROM) is equivocal or negative
  - Intimate partner violence screening
5. Consult the Physician immediately if any of the factors listed in Policy #5 is identified, or if the fetus demonstrates a Category 3 FHR pattern, or a Category 2 pattern with minimal variability, recurrent late and/or variable decelerations, or a prolonged deceleration.
  6. If no high-risk factors are identified, reassess the patient at least every 30 minutes or more often as indicated by her condition, to include:
    - FHR and periodic changes
    - Uterine activity and uterine resting tone
    - Blood pressure, pulse and respirations minimally every hour; pain scale assessment with vital signs
    - Repeat VE to assess for cervical change at least one (1) hour after the initial VE.
  7. After the monitoring/observation and the repeat VE, report the findings to the Physician.
  8. If the Physician orders parenteral pain medication for a patient in false or early labor, observe the patient for a minimum of one (1) hour following the administration of the medication, and reassess her pain level and her cervix prior to discharge. Notify the Physician if the pain medication is not effective, or if there is a change in the maternal or fetal status, other than the decrease in fetal heart rate variability which may be expected with medication administration.
  9. If the Physician orders that the patient be admitted, continue with the procedure for admission.
  10. If the Physician states he or she intends to arrange for transfer of the patient, continue with the process for maternal transport.
  11. If the Physician certifies that the patient meets the following criteria and is in false labor, document the assessment and the Physician's statement, and discharge the patient upon order of the Physician:
    - **Uterine activity:** Mild and/or irregular contractions without progression of cervical effacement or dilatation
    - **Fetal heart rate:** The presence of a Category 1 FHR pattern with reactivity **and** without decelerations, or a pattern appropriate for the gestational age. Document any assessment by a



Physician of the FHR pattern.

- **Maternal assessment:** Vital signs deemed by the Physician to be within the normal range for the patient and the absence of any acute high risk signs and symptoms as determined by the Physician based on the examination by the L&D competent RN.
12. If the Physician determines that the patient meets the following criteria, is in early labor and may safely be discharged, review the risks and benefits of discharge, as defined by the Physician, with the patient. If the patient chooses to be discharged, document the risks and benefits discussed with her, her statement of understanding of the risks and benefits, and her choice to be discharged; and discharge the patient upon order of the physician:
- **Uterine activity:** Mild and/or irregular contractions with minimal progression of cervical effacement or dilatation, as determined by the Physician based on the examination by the L&D competent RN.
  - **Fetal heart rate:** The presence of a Category 1 FHR pattern with reactivity **and** without decelerations, or a pattern appropriate for the gestational age. Document any assessment by a physician of the FHR pattern.
  - **Maternal assessment:** Vital signs deemed by the Physician to be within the normal range for the patient and the absence of any acute high risk signs and symptoms as determined by the Physician based on the examination by the L&D competent RN.
  - **Psychosocial:** The patient verbalizes understanding of when to return to the hospital or another available facility (*as indicated in the Discharge Instructions*) and states that she has reliable transportation and support.
13. If the patient is being discharged, provide appropriate discharge instructions, as discussed with the Physician, to the patient and family, as appropriate, to ensure continuity of care. Verify the patient's understanding of the discharge instructions.

## DOCUMENTATION FOR THE PATIENT BEING DISCHARGED:

1. Document the medical screening examination and communications with the Physician in the EHR. Verify that the Physician's orders are documented, including the orders for disposition of the patient.
2. Document the discharge instructions given to the patient and her statement of understanding of the instructions in the After Visit Summary and give her a copy of the instructions.
3. Complete the patient entry in the Outpatient Log.

## REFERENCES / RELATED POLICIES:

- American Academy of Pediatrics and American College of Obstetricians and Gynecologists. (2017). *Guidelines for Perinatal Care, 8 th Ed.* Elk Grove Village, Illinois: Author
- Caliendo C., et al. (2004). Obstetric Triage and EMTALA Regulations, *AWHONN Lifelines*, 8(5), 442-448
- Department of Health & Human Services, Centers for Medicare & Medicaid Services, *CMS Manual System*, Pub. 100-07 State Operations Provider Certification; Revisions to State Operations Manual Appendix V, Emergency Medical Treatment and Labor Act Interpretive Guidelines
- Previous Document Central policy number: LCT-WH-290



## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff - OBGYN, Peds/NICU, P&T, RN/MD	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	12/2023
Policy Committee	Lisa Yauchzee-Gac: Executive Director Nursing	12/2023

## Applicability

CA - Providence LCM MC Torrance



Origination: 07/2014  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 10/2023  
Next Review: 3 years after approval  
Owner: Scott Ciesielski: Chief Nursing Officer  
Policy Area: Patient Care Services  
References:  
Applicability: CA - Providence LCM MC Torrance

## Computerized Tube System (CTS)

### PURPOSE:

The Computerized Tube System (CTS) is used to transport supplies, records, specimens, medications, and other small items. The purpose of this policy is to establish procedures and guidelines for the operation of the system.

### I. ITEMS NOT APPROVED FOR TRANSPORT IN THE CTS SYSTEM

#### Laboratory

1. 24 hour urines
2. Formalin and/or alcohol preserved specimens
3. Empty blood bags
4. Used blood bags and blood IV sets, IV solutions that have been implicated in a possible transfusion reaction
5. Evacuated bottles
6. Blood products

#### Pharmacy

- ~~1. Chemotherapeutic drugs~~
- ~~2. Protein-based drugs (e.g., ReoPro, Albumin, IVIG)~~
- ~~3. Employee prescriptions~~
- ~~4. Controlled substances (II, III, IV)~~
- ~~5. Patient take-home meds~~
1. Refer to the Policy [Tube System Medication Guide](#) for a list of medications and pharmacy items not approved for transport in the CTS system.

#### Other

1. Drinks or food items

2. Contaminated supplies
3. Money/checks
4. Sharps
5. Patient valuables
6. Non-leak tight containers containing liquids

## II. PACKAGING

- A. Potentially infectious items must be contained and transported in a manner that prevents breakage, leakage or contamination of the system. In accordance with Standard Precautions and OSHA Bloodborne Pathogen regulations, all blood and body fluids must be handled as potentially infectious and potentially hazardous.
- B. Gloves must be worn when packaging and unpacking blood and body fluid specimens from secondary containment system from carriers.
- C. All workers handling specimens shall wear the appropriate personal protective equipment (PPE) as defined by standard precautions.
- D. Leakage is primarily due to:
  - Improper packaging and non-immobilization of contents
  - Use of non-leaktight containers or failure to tighten container lids
- E. If leakage has occurred or the processing of the specimen may cause aerosols or splashes, the specimen should be processed beneath a biohazard hood using PPE.
- F. To prevent spillage or breakage, remember:
  - Containment prevents leakage
  - Immobilization ensures integrity
- G. A combination of Ziploc biohazard bags and Zip N' Fold pouches will be used to immobilize and package items. "**Red**-trimmed" Zip N' Fold pouches are for **lab** specimens. "**Green**-trimmed Zip" N' Fold pouches are for **pharmacy** items. See the following for specific packaging procedures:
- H. Urine and Stool Specimens (120 mls or less plastic container)
  1. Make sure container cap is secure (Listen for the click).
  2. Place sealed, labeled specimen in clean Ziploc biohazard bag. (Bags are available in department.)
  3. Completely close Ziploc bag.
  4. Insert requisition paperwork in the outer section of the bag.
  5. Place Ziploc bag in a "red-trimmed" Zip N' Fold pouch.
  6. Seal pouch.
  7. Place pouch in carrier and send to Lab.
- I. Blood/Body Fluids - Vacutainer Tubes
  1. Place labeled tubes in Ziploc biohazard bag. Blood culture bottles: Only two (2) blood culture bottles should be sent at a time. Place lengthwise in carrier.
  2. Completely close Ziploc bag.



3. Place requisition in the outer section of the bag.
  4. Place Ziploc bag in "red-trimmed" Zip N' Fold pouch.
  5. Seal pouch.
  6. Place pouch in carrier and send to Lab.
- J. Culture Specimens (Cultures, sterile containers less than 150 mls)
1. Make sure specimen is securely contained in primary container.  
**NOTE: Do not send needle attached to syringe. Remove needle and replace with syringe luer lock tip cap. (Caps are available in department).**
  2. Place sealed, labeled specimen in Ziploc biohazard bag.
  3. Completely close Ziploc bag.
  4. Place requisition in outer section of the bag.
  5. Place Ziploc bag in "red-trimmed" Zip N' Fold pouch.
  6. Seal pouch.
  7. Place pouch in carrier and send to Lab.
- K. Zip N' Fold pouches that are in disrepair should be discarded.

### III. PHARMACY, AND SECURED TRANSACTIONS ~~AND HIPAA~~ PROCEDURES

- A. ~~The CTS linked to patient care areas shall be used as the preferred system of drug delivery service by the Pharmacy Department.~~
- B. ~~The CTS system will be utilized by the Pharmacy to send STAT doses (IV & oral), missing doses (IV & oral), and all routine drug orders linked via the CTS system.~~
- C. ~~Physician Orders: Physician orders are to be sent to the Pharmacy via the Order Scanning System. The CTS system shall be used as a back-up system when the scanning system is down. Use Pharmacy Main Station #80 when CTS system is used.~~
- D. ~~Items transported via the CTS system shall be received in a secure area. CTS stations designated as non-secured areas by the Pharmacist in Charge will be transported using the "Secure Transaction" procedures.~~
- E. ~~Secured Stations: 18, 21, 22, 24, 25, 28, 30, 32, 42, 82, 84, 85  
Non-Secured Stations: 11, 20, 23, 33, 40, 43, 51~~
- F. ~~Critical Care is a non-secured station. The following procedure will be followed:~~
- G. **PROCEDURES FOR SENDING A SECURE TRANSACTION**
  1. ~~Place properly latched carrier in dispatcher~~
  2. **ENTER Station #**
  3. **Enter Authority Code**
  4. **Press SEND**
  5. ~~Carrier will dispatch if message~~ **SELECTION ACCEPTED** ~~is displayed~~

6. Destination station will have a designated Authority Code. Nurse manager will be responsible to assign and provide the code to nursing staff and pharmacy.

7. Nurse manager will change "Authority Code" as needed for security reasons.

#### **H. PROCEDURES FOR RECEIVING A SECURE TRANSACTION**

1. Enter department Authority Code. Carrier will drop down into receiver station.

I. Items **NOT APPROVED** for transportation to and from the Pharmacy:

▪ Protein-based drugs (e.g., ReoPro, Albumin, IVIG)

▪ **CONTROLLED DRUGS II, III, IV**

▪ Take-home medications for patients or employees

▪ Chemo drugs

▪ **OTHER DRUGS AS PER JUDGMENT OF THE PHARMACIST** (e.g., caustics, flammables, acetic acids, etc.)

J. **Packaging Requirements for Transportation:**

1. Medication (Non-narcotic, Non-chemo)

a. Make sure primary container is properly sealed and labeled. Medications for patients shall follow the labeling policy.

b. Place container in plastic bag if needed.

c. Secure bag.

d. Place bag in "green-trimmed" Zip-N-Fold pouch.

e. Send to Nursing unit.

2. TPN and lipids are to be sent in "green-trimmed" Zip-N-Fold plastic bags.

A. The CTS linked to patient care areas shall be used as the preferred system of drug delivery service by the Pharmacy Department.

B. The CTS system will be utilized by the Pharmacy to send STAT doses (IV & oral), missing doses (IV & oral), and all routine drug orders linked via the CTS system.

C. Items transported via the CTS system shall be received in a secure area. CTS stations designated as non-secured areas by the Pharmacist-in Charge will be transported using the "Secure Transaction" procedures.

D. Refer to the Policy *Tube System Medication Guide* for medication packaging and "Secure Transaction" procedures.

## **IV. DECONTAMINATION PROCEDURES:**

A. Decontamination of the tubing system will be conducted when a substantial spill has occurred and has contaminated the tubing system. Shut down of the system will occur by zones.

B. The Plant Ops Department will follow departmental policies and procedures regarding how to perform the system clean-out process and utilize appropriate PPE.

1. A clean-out bottle with a hospital-approved disinfectant solution will be placed in the tube system and sent to the affected zones.



## V. SYSTEM SPILL PROCEDURES

The primary concern in the transportation of clinical specimens in a pneumatic tube system is leakage of the specimen into the carrier and potentially the tubing system, possibly exposing workers to hazardous materials. Leaking usually occurs when materials are improperly packaged. If a spill occurs the unit manager should provide training and to the employee that improperly packaged the specimen.

### A. Procedure for Users

**NOTE:** Always use Standard Precautions when handling carriers that may be contaminated.

1. When spillage occurs it should be visible through the plastic bag and precautions shall be taken.
2. If the leak is contained **WITHIN** the carrier:
  - a. Check the requisition to the specimen
  - b. Notify the unit that sent the specimen and request a new specimen
  - c. Discard the spilled specimen, disposable bio-hazard bag, and Zip N' Fold Pouch in a biohazardous container. Any broken glass should be disposed of in a sharps container
  - d. Place the carrier into a biohazardous bag and send to Central Sterile Processing for decontamination following manufacturers instructions and/or disposal of carrier if determined unable to be decontaminated.
3. If the specimen has leaked **OUT** of the carrier, the Plant Operations Department shall be notified to activate an emergency shut down of the system. The receiving station (usually laboratory) can also initiate an emergency shutdown (see decontamination procedure). When notifying Plant Operations state:
  - a. Receiving station's number
  - b. Sending station's number (if known)
  - c. Type of spill (specimen type and suspected amount)
  - d. Time the contaminated carrier arrived (or was first noticed)
  - e. Number of contaminated carriers that have arrived
4. Plant Operations is responsible for decontamination of the system and will return the system to service when cleaning completed.
5. Contact Environmental Services (1FIX) for any spills outside of the station. (Example: carpet cleaning).
6. Follow the steps under # 2 above for handling of the carrier and requesting a new specimen.
7. Plant Operations will report any spills to Infection Prevention Department.

### B. Plant Operations Action

1. Immediately verify that the system has been shut down. The system can be turned off at the System Control Center (SCC).
2. From the system transaction printout, verify from which station the carrier was dispatched and when. Use the riser diagram to determine the route that the carrier traversed from the source station to the destination station. Use the transaction printout to determine if other transactions used that route or any part of it before the system was shut off.



- a. Determine from the "System Traffic Display" if any transactions in process, when the system was shut off, used that route or any part of it.
- b. If any of these transactions used the same route or any part of it, determine their source and destination stations and clean out those routes in addition to the route in which the spill occurred.
3. Purge the entire system to clear the "Emergency Stop" status of the system. Be careful to assign contaminated stations as the recovery stations in those zones with contaminated routes. This procedure will eliminate the spread of contamination to other routes in contaminated zones.
4. From the SCC, individually schedule "Off" all stations on any zone with one (1) or more contaminated routes.
5. Assign "Off Dispatch" to any station on contaminated routes. This will allow cleanout carriers to be sent back to the stations from which they were dispatched.

**C. Procedure for Disinfecting Stations and Tubing**

The basic procedure consists of sending a carrier containing the cleanout bottle from station to station until all affected segments of the system have been traversed. This procedure will require one (1) person except when cleaning the interzone lines, which will require two people and telephone communication between them.

As the carrier travels through the tubing, the cleanout bottle dispenses the cleaning solution, while the carrier rubbing bands act as swabs.

1. While wearing protective clothing, use approved disinfectant solution. Consult Infection Prevention for recommendations regarding the correct disinfectant solution. Fill the cleanout bottle with cleaning/disinfectant solution to within 1/4" of the top holes on bottle.
2. Place the lid on the bottle.
3. While maintaining the upright position of the bottle, place it in a carrier.
4. Close and latch the carrier.

5. Periodically check the level of the cleaning solution. When there is less than an inch of solution left in the bottle, refill it and towel dry the carrier rubbing bands.

Disinfect the carpet in each affected station's receiver bin.

After cleaning, a slight amount of disinfectant/cleaning solution may remain in the tubing. This will not affect the system operation.

Use diagnostics to clean out any contaminated interzone lines. Turn the contaminated zones on.

Send the cleanout carrier back to yourself from all stations suspected of being contaminated to clean the contaminated routes.

Reassign all stations on "off" schedules to their original on/off schedules when cleanout is completed.

When the schedules have been entered, the system will be fully operational.

Use standard precautions when cleaning up the spill.

## **VI. CTS SYSTEM PREVENTIVE MAINTENANCE SCHEDULE**

**A. Scheduled Maintenance is performed at routine intervals using a combination of best practice and manufacture recommendations.**

1. The Plant Operations Manager will notify the user departments a minimum of three (3) days prior to scheduled down times along with approximate length of time the system will be non- functional.

2. Down time, when necessary, will routinely be scheduled between 10:00pm and 7:00am.
3. Departments will schedule their own messenger, if necessary, to transport specimens and other items during the scheduled downtime.
4. The Plant Operations Department will notify all user areas that the system is functioning again.

#### B. Contingency Plan for Unscheduled Down Time

1. Problems should be reported to Plant Operations at (1-FIX)
2. Within 15 minutes, user areas will be notified and given an assessment as to how long a station or the system will be down.
3. Stat items requiring immediate transport are to be handled by the individual area's personnel.
4. Each department is to use an alternate station in a different zone if possible.
5. The Plant Operations Department will notify all user areas that the system is functioning again.

## VII. TRAINING

All employees who will be using the pneumatic tube system will be educated on their hiring unit, regarding proper packaging procedures, system use and use of PPE when applicable.

Education will occur at the unit level for newly hired employees and with any change in work flow/processes.

## VIII. USERS

This system consists of multiple computerized tube stations. Station numbers are assigned as they are implemented.

### TUBE STATION DIRECTORY

HERITAGE BUILDING			Zone	HANNON TOWER			Zone
Angio Recovery Unit (ARU)	11	2		ED Main A	82	1	
Blood Bank / Pathology	14	2		ED Fast Track	84	3	
Dietary	16	2		ED Main B	85	3	
Mother Baby North/Peds	32	1		ICU - Station B	25	3	
NICU	30	1		ICU - Station D	24	3	
Newborn Nursery	36	1		IV Prep Room	81	1	
Operating Room (OR)	21	1		Pharmacy	80	3	
Med Surg Oncology	42	1		4th Med / Card	43	3	
CDOU	40	1		1st Surg / Ortho	18	3	
Radiology	15	2		Women & Children's Health	33	3	
P.A.R.R.	20	1					
Cath Lab	51	2		<b>TECH CENTER BUILDING</b>			<b>Zone</b>
Outpatient Diagnostic	50	2		Laboratory	10	2	
PCU	22	1		Laboratory (Alternative)	12	1	
PCU (West)	23	1		Laboratory (Back-Up)	13	2	



## IX. BASIC SYSTEMS/OPERATING INSTRUCTIONS

### A. Sending an Item

1. The message **STATION READY** indicates your station is ready for sending a carrier. If it does not display this message, see **DISPLAY MESSAGES** section of this policy.
2. Place items to be sent in an empty carrier utilizing the appropriate Zip N' Fold bag for biohazard (Red) or medication (Green). Ensure that contents are immobilized and/or securely contained. At no time should a red bag and green bag be sent together in a single container.
3. Close carrier and ensure that both latches are engaged, and that no packaging material is outside the carrier.
4. Place carrier in dispatcher.
5. Select the destination station number from the Station Directory and enter this number using the keypad. **NOTE:** Do not use pens or pencils to push the system keypad.
6. Press **SEND**.
7. The message **SELECTION ACCEPTED** indicates your carrier has been accepted for processing and will be processed as soon as possible.
8. For messages that may be displayed when a carrier cannot be dispatched, see **DISPLAY MESSAGES** section of this policy.

### B. Clearing a Transaction

1. If an error is made while keying an entry, press **CLEAR** and start over.
2. If an improper keyboard entry is made, a short "beep" will sound. Press **CLEAR** and start over.
3. If you wish to stop a transaction after the **SEND** button has been pressed and **SELECTION ACCEPTED** is displayed, press **CANCEL**. **NOTE:** The transaction cannot be cancelled if the dispatcher has started to move.
4. If **TRANSACTION WAS ABORTED** is displayed, press **CANCEL** and start over.

### C. Receiving an Item

1. The messages **INCOMING CARRIER** and **INCOMING SECURE CARRIER** indicate carriers will be arriving at your station.
2. Remove indicator light indicates a tube has arrived in the tube station.
3. Remove carriers promptly to prevent receiver bin from becoming full and shutting off station, observing Standard Precautions when necessary. **NOTE:** If a carrier is suspected of being contaminated, follow the System Spill Procedures for Users contained in this policy.
4. If carriers or latches are damaged, remove from system and send to Plant Operations to be repaired.
5. If **RETURN SURPLUS CARRIERS** is displayed, send extra carriers to Station "O" or use "empty send" button (if applicable to station).
6. If you receive a tube in error, return to sender.

### D. Carriers

1. There is a minimum PAR level of carriers for each tube station. Surplus carriers should be returned to destination "O" (press the "O" **SEND** key). Hoarding carriers will slow down the system.

### E. Zip N' Fold Bags

1. There is a minimum PAR level of bags for each tube station determined by each unit based on need and can be adjusted as necessary. Each unit is responsible for rounding on their station daily and returning any excess bags and/or requesting additional bags to return the station to a PAR level. (Red = Lab; Green = Pharmacy).

### DISPLAY MESSAGES

The following are other display message possibilities and the appropriate action required.

MESSAGE	ACTION
Station Full	Empty your receiver bin
Station Scheduled Off	Call Plant Operations (1-FIX) 31349
Station Signed Off	See Special Function #83
Station Not In Service	Call Plant Operations (1-FIX) 31349
Traffic Forwarded to "X"	See Special Function #75
Secure Carrier Arrived/Secure Authority Code	See Special Function #73
Selection Full/Try Later	Call Destination Station to empty receiver bin
Selection Does Not Exist	Check selection & try again
Selection Scheduled Off	Call Plant Operations (1-FIX) 31349
Selection Signed Off	Call Destination
Selection Not In Service	Try again later
Selection Not Permitted	Call Plant Operations (1-FIX) 31349
Transaction Aborted	Press "Cancel"/try again
Selection Accepted	No action required
Downtime	Call Plant Operations (1-FIX) 31349

***This policy was developed in collaboration with the following involved departments:***

Facilities Management, Infection Prevention, Laboratory Services and Patient Care Services and Ancillary Services

<b>Policy #:</b> LCT-IM-304	<b>Reviewed:</b> 8/00, 1/03, 11/05, 5/08	<b>Revised:</b> 8/00, 1/03, 10/08, 10/11, 5/18
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### Attachments

No Attachments



## Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention, P&T	Mayra Graves: Medical Staff Coordinator	pending
CPC	Cindy Wishon: Nurse Educator [PH]	12/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	10/2023
Policy Committee	Scott Ciesielski: Chief Nursing Officer	10/2023

## Applicability

CA - Providence LCM MC Torrance



# Providentia

Little Company of Mary  
Medical Center  
Torrance

Origination: 09/2014  
Effective: 1 Days After Approval  
Last Approved: N/A  
Last Revised: 05/2017  
Next Review: 3 years after approval  
Owner: Jamie Jolly: Senior Manager  
Infection Prevention  
Policy Area: Infection Prevention  
References:  
Applicability: CA - PH&S Little Company of Mary Service Area

## Employee Food and Drink in Patient Care Areas

### POLICY

In keeping with the mission and values of Providence Health & Services, in order to reduce the risk of disease transmission through bloodborne pathogen exposure, this policy serves to define the guidelines for food and drink in patient care areas.

### DEFINITIONS

- OPIM - Other Potentially Infectious Materials
- OSHA - Occupational Safety and Health Administration

### PROCEDURE / GENERAL INSTRUCTIONS

1. Adapted from the Exposure Control Plan Bloodborne Pathogens:
  - A. The consumption of food and drink is prohibited in areas where the potential for exposure to blood or OPIM exists, or where there is potential for contamination of the work surface.
2. Drinks in Patient Care Areas
  - A. As long as blood or OPIM is not present, drinks with lids may be allowed:
    - i. In the business area of the nurse stations
    - ii. Physician dictation areas
    - iii. Other area specifically designated by unit managers
  - B. Any location must be kept separate from areas where lab specimens or contaminated equipment are handled
3. Employee Requirements:
  - A. All beverage containers must have a tight-fitting lid or cover
  - B. Cans and open cups are prohibited
  - C. All containers shall be removed by the employee, no later than at the end of their shift.
4. Prohibited Practices:
  - A. Eating, drinking, smoking, applying cosmetics, and handling contact lenses are prohibited in the



following work areas:

- i. Direct patient care areas
  - ii. Surgery and procedure rooms
  - iii. Charting pods/areas outside patient rooms
  - iv. Any area where there is medication, patient care equipment, specimens and/or potential bloodborne pathogens
- B. Food in patient care areas
- i. Staff shall not keep food and/or eat at nursing stations, or any other patient care area
  - ii. Eating shall be reserved for break times, and done in specifically designated areas.

## REFERENCE(S) / RELATED POLICIES

- U.S. Department of Labor, OSHA/ **Final Rule on Occupational Exposure to Bloodborne Pathogens** – 57:6404
- Document Central policy number: LCT-IC-165
- Related Policies: Exposure Control Plan for Bloodborne Pathogens

### Attachments

No Attachments

### Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention (Both)	Mayra Graves: Medical Staff Coordinator	pending
Med Staff - Infection Prevention (Both)	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	12/2023
Policy Committee	Jamie Jolly: Senior Manager Infection Prevention	12/2023

### Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



**Origination:** 02/2021  
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**Last Approved:** N/A  
**Last Revised:** 02/2021  
**Next Review:** 3 years after approval  
**Owner:** Candice Washilewski: Executive Director Nursing  
**Policy Area:** Infection Prevention  
**References:**  
**Applicability:** CA - PH&S Little Company of Mary Service Area

## Pneumococcal Prevention and Control Plan

### POLICY

In keeping with the mission and values of Providence, it is the policy of Providence Health System-South Bay Service Area to adopt this clinical standard for use in the following\*:

#### Providence Little Company of Mary Medical Center Torrance:

X	Acute Care
X	Transitional Care Center
	Providence Little Company of Mary Home Health

#### Providence Little Company of Mary Medical Center San Pedro:

X	Acute Care
X	Sub-Acute Care Center
X	Psychiatric Unit
X	Acute Rehabilitation
X	Chemical Dependency Unit

\* An X indicates that this location will be included in the policy.

### PURPOSE

The purpose of this policy is to prevent pneumococcal disease and related complications in at-risk patients, specifically through appropriate vaccination.

### BACKGROUND

Pneumococcal disease can cause a multitude of infections, such as meningitis, bloodstream infections, pneumonia, and ear infections. Pneumococcal bacteria spread from person-to-person by direct contact with respiratory secretions, such as saliva or mucus. The pneumococcal vaccine protects against many types of pneumococcal infections (depending on the specific vaccine), and the Centers for Disease Control (CDC) recommends the vaccine for use in infants, young children, and adults 65 years or older.



# PREVENTION AND CONTROL MEASURES

Strategies for the prevention and control of pneumococcal disease include appropriate screening and vaccination of all eligible patients. CDC recommends vaccination of patients age 65 years and older and in persons over that age of 2 years who are at high risk for pneumococcal disease due to underlying medical conditions. These medical conditions include:

- A. Sickle cell disease
- B. HIV infection
- C. Immune-compromising infections
- D. Diabetes
- E. Chronic heart, liver, kidney, or lung disease
- F. Alcoholism
- G. Smoking

## Vaccination

All patients age 65 years or older or at high risk for pneumococcal disease should receive the vaccination according to current national recommendations. Vaccination is the primary measure to prevent infection or development of illness from pneumococcal disease, thereby preventing complications.

- A. Admitted patients are screened and vaccinated in accordance with current national and local recommendations.
  - 1. All inpatients age 65 years or older, or those patients with certain underlying medical conditions (*please see above*), will be screened for the pneumococcal vaccine. If the vaccine is not administered, the nurse should indicate the reason (*e.g., the patient received the vaccine elsewhere, the patient refused, etc.*).
  - 2. Federal and state regulations authorize a registered nurse to administer the pneumococcal vaccine without a physician's order.

## Infection Control Measures

In addition to pneumococcal vaccination, the following infection control measures are recommended to prevent person-to-person transmission:

- A. Standard Precautions:
  - 1. During the care of any patient with symptoms of a respiratory infection, healthcare personnel should adhere to Standard Precautions. (*Refer to Standard Precautions and Transmission-based Isolation Precautions policy*)
- B. Education:
  - 1. Personnel will be educated about the signs and symptoms of pneumococcal disease, transmission and prevention strategies.
- C. Respiratory Hygiene/Cough Etiquette:
  - 1. Respiratory hygiene/cough etiquette will be initiated at the first point of contact with a potentially

infected person to prevent the transmission of respiratory tract infections in all settings. Respiratory Hygiene/Cough Etiquette include:

- a. Posting visual alerts instructing patients and persons who accompany them to inform healthcare personnel if they have symptoms of respiratory infection.
- b. Providing tissues or masks to patients and visitors who are coughing or sneezing so that they can cover their nose and mouth.
- c. Ensuring that supplies for hand washing are available where sinks are located; providing dispensers of alcohol hand sanitizer in other locations.
- d. Providing space for coughing persons to sit at least three (3) feet away from others, if tolerated.

D. Restrictions for Ill Visitors and Ill Caregivers:

1. Discourage persons with symptoms of a respiratory infection from visiting patients. Post notices to inform the public about visitation restrictions.

## REFERENCES

- CDC. Pneumococcal Vaccination. Last updated 12/14/2018. <https://www.cdc.gov/pneumococcal/vaccination.html>
- CDC. Pneumococcal Risk Factors and Transmission. Last updated 11/07/2017. <https://www.cdc.gov/pneumococcal/about/risk-transmission.html>
- CDC. Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Morb Mortal Wkly Rep 2015 / 63(34);944-947. DOI: <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6434a4.htm>

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Infection Prevention, P&T	Mayra Graves: Medical Staff Coordinator	pending
Infection Prevention, P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
Policy Committee	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023



## **Applicability**

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

COPY



# Provident

Little Company of Mary  
Medical Center  
Torrance

Origination: 04/2021  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 04/2021  
Next Review: 3 years after approval  
Owner: Edgar Flemate: Director Facilities  
Policy Area: Facilities  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## POM: Ice Machine Care and Maintenance

### PURPOSE:

The purpose of this policy is to define appropriate measures for the safe storage and dispensing of ice. Ice Machines shall be maintained in accordance with manufacturer specifications and included in the POM Preventive Maintenance Program.

The POM Department will be responsible for routine cleaning and maintenance of ice machines, both dispenser and bin types in patient care areas. In the event of ice machine failure, portable ice carts may be used by nursing/dietary staff. At that time dietary personnel shall be responsible for the routine cleaning of portable ice carts and the storage of ice scoops. Ice for patient use shall be dispensed only by employees.

### PROCEDURE:

To perform routine maintenance POM staff/vendor shall:

- Disconnect the unit.
- Remove and discard all ice.
- Allow the chest to warm to room temperature.
- Check the need for possible repair of any portion of the machine.
- Inspect for insect or rodent infestation.
- Check the gasket around ice chest door (open compartment models only)
- Pay particular attention to door tracks, grids & gaskets.
- Use clean rags or disposable wipes to scrub all surfaces including ice storage compartments with a fresh bleach solution.
- Circulate 1600 ppm bleach solution throughout the entire ice-making and storing system, or according to manufacturers recommended cleaning and sanitizing procedures.
- After cleaning, rinse all surfaces of the compartment with potable water, allow it to dry and return unit to service.

### REFERENCE:

- Document Central Policy Number: LCT-POM-029



## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Infection Prevention	Mayra Graves: Medical Staff Coordinator	pending
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024
Policy Committee	Edgar Flemate: Director Facilities	01/2024

## Applicability

CA - Providence LCM MC Torrance



# Provident

Little Company of Mary  
Medical Center  
Torrance

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Effective: Upon Approval  
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Last Revised: 04/2021  
Next Review: 3 years after approval  
Owner: Edgar Flemate: Director Facilities  
Policy Area: Facilities  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## POM: Standard Precautions and Isolation Precautions

### STANDARD/ISOLATION PRECAUTIONS

1. Standard precautions shall be observed for all cases of entry into an occupied patient room.
2. When it is necessary for repairs to be made in a room where isolation precautions are in effect, POM staff will use appropriate personal protection equipment according to Isolation precaution in use and posted.  
(Refer to Isolation Precautions P & P in Hospital Administrative Manual)

### PERSONAL PROTECTIVE EQUIPMENT GLOVES

1. Gloves are worn to prevent the spread of infection.
2. Gloves should be worn as indicated by Isolation Precaution signage when working on a stopped-up drain line, toilet and anything where safety of POM personal is in question.
3. When putting on gloves' hands should be clean and dry, pull gloves on by the cuff being careful not to tear gloves, gloves should fit fully with fingers fully into gloves.

### GOWNS

A gown is worn to protect personal or visitors from direct contamination with the patient's secretions, excretions, or from the surroundings.

1. Gowns should be long enough to completely cover the uniform.
2. Gowns should only be worn once and then disposed of as trash.
3. Hold gown at neck opening and let it unfold, the open part should be facing you, put arms in sleeves so that the opening is to your back. This will cover your uniform and prevent contamination while you are working. Tie the gown in the back to prevent accidental contamination.
4. If wearing gown or mask remove gloves first.
5. Wash hands and arms after gloves are removed

# MASKS

Masks are to be worn to prevent the spread of airborne infection.

1. Masks must be used only once, must never be lowered around the neck or put on top of head or re-used.
2. Masks should cover the nose and mouth, if glasses are used the mask should fit snugly over nose and under the bottom of eyeglasses. This will prevent glasses from steaming. Handle the mask as little as possible.
3. Masks must be changed after 15 minutes of use. Masks become ineffective when moist and must be discarded in the appropriate manner.
4. **Do Not** touch the front of mask while it is being worn.

## REMEMBER:

Dispose of masks, gloves and gowns inside of patient room, place in container near door. Wash hands and arms thoroughly before leaving room.

## REFERENCE:

- Document Central Policy Number: LCT-POM-083

### Attachments

No Attachments

### Approval Signatures

Step Description	Approver	Date
Infection Prevention	Mayra Graves: Medical Staff Coordinator	pending
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024
Policy Committee	Edgar Flemate: Director Facilities	01/2024

### Applicability

CA - Providence LCM MC Torrance



Current Status: *Pending*

PolicyStat ID: 14773850



# Providence

Little Company of Mary  
Medical Center  
Torrance

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Last Revised: 08/2017  
Next Review: 3 years after approval  
Owner: Candice Washilewski: Executive  
Director Nursing  
Policy Area: Patient Care Services  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## Refrigerator/Freezer Logs

### PURPOSE:

The purpose of this policy is to establish a method for recording and reporting variation in food refrigerators/freezers.

### PROCEDURE:

1. All patient food refrigerators/freezers will be monitored daily when the department is open.
2. The temperatures will be documented on the "Refrigerator/Freezer Temperature Log".
3. Normal ranges for temperature are:
  - A. Food refrigerator - 41 degrees F or below
  - B. Food freezer - 0 degrees F or below
4. If the temperature is not within normal range, an asterisk (\*) will be placed next to the temperature and the Service Center will be notified for adjustment/ corrections. If Plant Operations and Maintenance (POM) determines that the refrigerator/freezer has failed, Nutrition and Food Services will be notified for appropriate follow up.
5. Temperature logs will be maintained for twelve (12) running months.

### REFERENCE(S) / RELATED POLICIES:

- Document Central policy number: LCT-PC-140

### Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Scott Ciesielski: Chief Nursing Officer	11/2023
Policy Committee	Patti Hamaguchi: Executive Director Quality	11/2023

## Applicability

CA - Providence LCM MC Torrance

COPY



# Providence

Little Company of Mary  
Medical Center  
Torrance

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Last Revised: 12/2023  
Next Review: 3 years after approval  
Owner: Maria Aoki: Director  
Rehabilitation Services  
Policy Area: Therapy Services  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## Therapy Services: Physical Therapy Wound Care Evaluation and Treatment

### POLICY

In keeping with the mission and values of Providence St. Joseph Health the Physical Therapy department will perform skilled wound care, including an evaluation, create a treatment plan, dressing applications, sharp debridement (if necessary), reassessments, measurements and upload photographs of the wound/wounds into EPIC, all under the direction of a physician.

### DEFINITIONS

Debridement - the removal of damaged/dead tissue or foreign objects from a wound

Physical Therapist Assistances can not perform evaluations or reassessments

### PROCEDURE/GENERAL INSTRUCTIONS

- Review Physical Therapy evaluation and treatment order in electronic medical record (EMR) to verify that it was entered by a qualifying provider (MD, DO, PA, NP)
- Physical Therapist/assistant will review patient/wound history in the EMR and with the patient, family, caregiver, nurse or physician - as available or able.
- Physical Therapist/assistant along with the Rehab Tech will provide privacy and explain the process for the evaluation/treatment
- Physical Therapist/assistant and Rehab Tech will wash their hands. Patient's tray table will be wiped down with a saniwipe and allowed the appropriate wet time per manufacture's instructions
- Therapist and Rehab Tech may don isolation gown, gloves and mask
- Patient will be positioned for easy access to the wound site, and ensuring comfort to the patient
- Dirty dressings and gloves will be removed and discarded in the trash ~~can~~ unless dressings are heavily soiled with blood then they will be put in a ~~red~~biohazard bag and taken to the soiled utility room
- Therapist will irrigate wound/s with normal saline or other indicated solution, then wiped clean with a clean gauze
- On evaluation and at the weekly treatment the wound will be measured and photographed with the date, location and MRN visible in photo
- Therapist will perform instrumental debridement as indicated
- Therapist will apply approved topical, clean dressing, secure with tape and/or netting, date and initial



• dressing

- Remove gloves, wash hands
- Individual medications/ointments will be scanned into the EMR at time of application and kept in locked box in patients room
- Wipe IPAD with alcohol wipe and dispose of dirty instruments appropriately
- Document evaluation/treatment in EMR

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff - Infection Prevention	Mayra Graves: Medical Staff Coordinator	pending
CNO	Scott Ciesielski: Chief Nursing Officer	01/2024
Policy Committee	Patti Hamaguchi: Executive Director Quality	12/2023
Policy Committee	Maria Aoki: Director Rehabilitation Services	12/2023

## Applicability

CA - Providence LCM MC Torrance

## **PURPOSE**

The purpose of the Infection Prevention Program (IPP) is to identify infections and to reduce the risks of disease transmission via the development and implementation of preventive measures. The mission of this program is to facilitate safe, cost-effective care of our patients, staff, and visitors. In particular, the IPP is designed to reduce or prevent the acquisition of healthcare-associated infections (HAIs) by providing education, training, and support to all staff regarding the principles and practices of infection prevention. The IPP plan is updated annually and is revised as necessary to accommodate real-time technological advances, new information, and revelatory findings. The IPP team oversees Providence Little Company of Mary Medical Center Torrance (PLCMMCT) and Torrance Transitional Care Center/Unit (TCC) on the same license.

## **THE INFECTION PREVENTION PROGRAM INCLUDES:**

- I. Scope of Service**
- II. Authority / Responsibility / Program Management / Resource Allocation**
- III. Data Collection**
- IV. Environment**
- V. Caregiver Health**
- VI. Mitigation of Infection Risks**
- VII. Intervening Directly to Prevent Transmission of Infectious Diseases**
- VIII. Education and Training of Healthcare Workers**
- IX. Education of Patients**
- X. Reporting Systems**
- XI. Emergency Management**
- XII. Transitional Care Unit**
- XIII. Home Health**
- XIV. Resources**
- XV. Comprehensive Infection Prevention Surveillance Plan**
- XVI. Organizational Flowcharts**

## **I. Scope of Service**

- A. Infection prevention is a facility-wide patient safety component involving all departments. The Manager of Infection Prevention, supported by the Infection Prevention and Blood (IPB) Committee, determines the specific focus of surveillance, education, and consultation efforts on an ongoing basis, depending on hospital epidemiology, community disease trends, and real or perceived local or global threats.

## **Providence Little Company of Mary Medical Center Torrance**

### **2024 Infection Prevention Program Plan**

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B. Epidemiologic data is used to plan, implement, evaluate, and improve infection prevention strategies. Prevention efforts include, but are not limited to, activities such as:

1. Measuring, monitoring, evaluating, and reporting infection data and program effectiveness.
2. Addressing outbreaks, epidemics, and unusual occurrences in a timely manner.
3. Complying with mandates of licensing and accrediting agencies.
4. Focusing on high volume services or procedures and/or populations that may be at high risk for infection.
5. Identifying and reporting communicable diseases in accordance with California Code of Regulations (CCR) Title 17. [IC.02.01.01].
6. Working collaboratively with the local health officer and appropriate Departments of Public Health.

## **II. Authority / Responsibility / Program Management / Resource Allocation [IC.01.01.01; CMS 482.42(A), California Health and Safety Code Section 1288.45 and 1288.95]**

The IPB Committee, through its chairperson or physician members, is given authority by the Executive Committee to institute any appropriate control measures or studies. Likewise, the IPB Committee may recommend corrective action concerning an infection event that poses risks to any patient, visitor, or staff member.

### **A. MEMBERS OF THE IPB COMMITTEE**

1. Physician Chair: Dr. Eric Yang, Infectious Disease (voting member).
2. Manager of Infection Prevention: Jamie Jolly, RN, CIC (voting member).
3. Infection Preventionists: Angela Duncan RN, MSN, CIC, CPHQ, Danielle DeSanty, PT, DPT, CIC and Cecile Chantrapornlert, RN, at TCC.
4. Stakeholder Representatives may include Medical Staff, Administration, Nursing Leadership, Quality Management, Surgical Services, Women's Services, Caregiver Health, Emergency Services, Food Services, Microbiology, Pharmacy, Environmental Services, Sterile Processing, Facilities Services, Outpatient Services, or Respiratory Services and Public Health.
5. Other direct and indirect patient caregivers are invited as needed.

### **B. DUTIES AND RESPONSIBILITIES OF THE IPB COMMITTEE**

1. Success of a ministry-wide IPP requires collaboration with all interdisciplinary teams, hospital departments, and units. This collaboration is vital for gathering and interpreting data, designing interventions, and effectively implementing those interventions. Participation of Executive Leadership in the IPP aids in decision-making and execution of corrective action.



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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2. The IPB Committee oversees a ministry-wide IPP. All ministry components and functions are integrated into Infection Prevention activities. The IPB Committee:
  - a) Reviews and approves the Infection Prevention Risk Assessment and the IPP, subsequently defining epidemiologically important issues, setting specific annual objectives, and modifying the IPP to meet those objectives as needed.
  - b) Reviews surveillance data for trends in infections, clusters, hospital-acquired infections (HAIs), or any unusual pathogens that exceed established thresholds.
  - c) Recommends corrective action(s).
  - d) Reviews, in conjunction with pharmacists, antibiotic susceptibility/resistance trends and makes recommendations for judicious use of antibiotics as appropriate.
  - e) Reviews and issues reports on infection control risk assessments (ICRA) as required for construction and renovation projects.
  - f) Institutes appropriate control measures or studies, including patient testing, patient isolation, or environmental sampling when there is reasonable concern for the well-being of patients, personnel, volunteers, visitors, or the community.
  - g) Reviews Infection Prevention Policies and department-specific infection-related policies at least every three (3) years, unless otherwise specified. Remains current with regulatory guidelines and standards related to infection prevention.
  - h) Submits reports to the Medical Executive Committee quarterly to convey findings and recommendations, which then reports to the Regional Ministry Board.

#### C. RESPONSIBILITIES OF THE INFECTION PREVENTION DEPARTMENT [IC.01.01.01], [CMS 482.42 (1) (a)]

1. The Manager of Infection Prevention has been given authority through the IPP and is responsible for:
  - a) Implementing policies concerning the management of infections and communicable diseases.
  - b) Reporting to the Executive Director of Quality and the Senior Director of Infection Prevention.
  - c) Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases.
  - d) Coordinating infection prevention activities and projects within the hospital.
  - e) Facilitating ongoing monitoring of program activities and intervention effectiveness.
  - f) Coordinating with other Infection Preventionists to implement recommendations per public health authorities.

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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- g) Observing the following hours of operation:
    - (1) Normal operating hours are Monday through Friday, 8AM – 4:30PM.
    - (2) During holidays and after hours, the house supervisor notifies the Infection Preventionist for escalated concerns by hospital staff for consultation.
  - h) Consulting with California Department of Public Health (CDPH) for public health issues or suspected communicable diseases.
2. The Infection Preventionists have the responsibility for day-to-day operational tasks, which include, but are not limited to:
- a) Instituting appropriate surveillance, precautions, isolation, and requesting cultures.
  - b) Maintaining ongoing communication with nursing departments, surgical services, clinical support services, laboratory, and ancillary departments regarding patients with infections and those at greatest risk for HAIs or other epidemiological issues within the community.
  - c) Sharing HAI information with ministry leadership, nursing leadership, risk management, and quality departments. Information sharing may occur via event reporting, multidisciplinary case review drill downs, clinical monitoring, committee reports, and/or verbal communication on an ongoing basis.
  - d) Working cooperatively with the quality and risk departments to identify and respond to sentinel events pertaining to infection control issues.
  - e) Collaborating with multidisciplinary teams to implement infection prevention-based quality and performance improvement strategies.
  - f) Quarantining or securing areas within the ministry that are deemed unsafe per infection prevention standards.

#### D. QUALIFICATION MAINTENANCE FOR INFECTION PREVENTION MEMBERS [IC.01.01.01]

- 1. The Manager of Infection Prevention maintains Certification in Infection Prevention and Control (CIC) through the national Certification Board of Infection Control and Epidemiology (CBIC).
- 2. Infection Preventionists maintain competency and remain current through educational opportunities available through various professional organizations relevant to the position. These educational opportunities may include webinars, self-learning modules, CIC credentialing, and hospital programs.
- 3. The Manager of Infection Prevention maintains membership in the National Association for Professionals in Infection Control and Epidemiology (APIC) and the local APIC Chapter.



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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4. The IPB Chairperson or designated hospital epidemiologist participates in continuing medical education training programs offered by the Centers for Disease Control (CDC) and Society for Healthcare Epidemiologists of America (SHEA), or other recognized professional organizations, as needed. Documentation of attendance is placed in the physician's credentialing file.

#### E. RESOURCE ALLOCATION [IC.03.01.01]

Hospital Senior Leadership allocates necessary resources for the IPP and provides systems to support Infection Prevention activities. Staffing the Infection Prevention department, factoring expertise and quantity, is determined by the goals and objectives of the IPP.

1. Executive leadership reviews, on an ongoing basis, the resources and the effectiveness of the hospital's infection prevention activities and supports the department.
2. 2024 staffing includes:
  - a) 0.66 FTE Infection Prevention & Control Manager
  - b) 2.0 FTE Infection Preventionists at PLCMMCT
  - c) 1.0 FTE Infection Preventionist at TCC
3. Electronic systems are used to access information. The Infection Prevention department has computers for each staff member, current software to support analysis, a designated printer, a confidential fax, an electronic rounding tool and a copier.
4. The ministry laboratory staff regularly collaborates with Infection Preventionists for standard monitoring, providing additional services in special cases as required.
5. Equipment, supplies, and resource materials are provided to support Infection Prevention activities.
6. Infection Prevention personnel have appropriate access to medical and other relevant records and have working relationships with the Quality Department, who can provide information on the adequacy of the institution's compliance to regulations, standards, and guidelines.
7. Support is provided to assist in compliance of reporting required infection surveillance information to external organizations.

#### F. SHARED RESPONSIBILITIES OF THE INFECTION PREVENTION PROGRAM

1. The prevention of infections is a shared responsibility among all clinical and non-clinical staff in the hospital.
  - a) Medical Staff Responsibilities:
    - (1) The Medical Directors and Medical Staff provide expertise from their respective areas and disciplines, in conjunction with the members of the IPB Committee, to help prevent and manage infections.



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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- (2) The Medical Staff works cooperatively with the Infection Prevention department in considering practices, processes, and other evidence-based improvements.
- (3) The Medical Staff works in conjunction with regulatory and public health agencies when appropriate.
- b) Department-Specific Responsibilities:
  - (1) The Managers/Directors are responsible for monitoring employees and assuring compliance with Infection Prevention policies and procedures. Responsibilities include, but are not limited to:
    - (a) Revising and updating departmental policies relating to Infection Prevention in collaboration with the Infection Prevention personnel.
    - (b) Ensuring proper patient care practices and product safety.
    - (c) Ensuring proper documentation and necessity of invasive devices (central lines, ventilators, and urinary catheters).
    - (d) Orienting existing and new staff on Infection Prevention issues and risks specific to their job duties, i.e., use of safe sharps and medical waste handling, Infection Prevention policies, and National Patient Safety Goals (NPSG).
    - (e) Coordinating with Infection Prevention to plan and implement educational or in-service programs on the prevention of infections.
    - (f) Monitoring compliance with hand hygiene policies.
    - (g) Assuring that healthcare workers use safe and effective practices for all cleaning, disinfection, and sterilization, as appropriate for their job functions.
    - (h) Monitoring compliance with use and documentation related to high-level disinfection, as appropriate for their job functions.
    - (i) Monitoring cleanliness of departments.
    - (j) Participating in multidisciplinary drilldowns of HAIs and appropriate follow-up with Nursing staff afterward.
- c) Caregiver Responsibilities: All healthcare workers of the organization have responsibilities in preventing the spread of infection and:
  - (1) Adhering to hand hygiene guidelines.
  - (2) Adhering to Infection Prevention policies (Infection Prevention policies are located on the intranet).

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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- (3) Avoiding food and drink in areas where blood or bodily fluids are handled.
- (4) Using safe sharps and safe handling procedures to avoid blood-borne pathogen exposure.
- (5) Participating in the review of Infection Prevention data within their departments.
- (6) Completing orientation and annual education review and test.
- (7) Participating fully in the Caregiver Health Program and complying with required immunizations.
- (8) Notifying the Infection Prevention department of infection-related issues or potential concerns.
- (9) Not reporting to work when sick or with signs and symptoms of illness.

#### G. COLLABORATION

1. The Infection Prevention Manager and Infection Preventionists are involved in regulatory agency meetings and in Providence Health System Teams.
  - a) Regulatory agency involvement includes:
    - (1) In-person meetings with Los Angeles County Department of Public Health (CDPH) liaison.
    - (2) CDC/National Health and Safety Network (NHSN) webinars and meetings.
    - (3) CDPH webinars and meetings.
  - b) Providence Health System and Regional involvement.

### III. Data Collection

#### A. SURVEILLANCE AND MONITORING INCLUDES BUT IS NOT LIMITED TO:

1. Monitoring high-volume/high-risk & low-volume/high-risk procedures.
2. Evaluating or consulting on new programs.
3. Monitoring construction/renovation projects in conjunction with Plant Operations, Environment of Care, Safety, and Risk Management teams.
4. Compiling and analyzing surveillance data, presenting findings, and making recommendations to the IPB Committee, to other departments, and to medical leadership as appropriate.
5. Using baseline surveillance data to determine if an outbreak/cluster is occurring.
6. Investigating trends of infections, clusters, and unusual infections.

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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7. Conducting or facilitating infection prevention and control environmental and isolation rounds.
8. Using the EPIC clinical documentation system, Buggy, and any other database as appropriate.
9. Reviewing microbiology notification of Acid-Fast Bacilli (AFB) and other unusual/significant pathogens.
10. Reviewing reports from the laboratory.
11. Reviewing the isolation list and performing rounds.
12. Reviewing reports from other facilities with knowledge of an infection that may have occurred at this facility.
13. Reviewing public health reports.
14. Regular review of surveillance data.
15. Working with Case Management or other staff reports of suspected or known infections.
16. Reviewing Caregiver Health reports reflecting epidemiologically-significant healthcare worker infections and/or unusual employee related trends.

#### B. INFECTION DEFINITION

1. HAIs are identified using the most current definitions for healthcare-associated infections. Acute care uses CDC/NHSN and TCC uses NHSN and McGeer definitions. HAI outcomes are trended over time.
2. HAI Outcome Measures:
  - a) HAI data (summary events data or numerator/denominator) is entered into NHSN when applicable and analysis reports are pulled for review, trending, and graphing.
  - b) Examples include:
    - (1) Device-associated HAI measures:
      - (a) Standardized Infection Ratio (SIR) = observed over expected infections.
      - (b) Standardized Utilization Ratio (SUR) = observed over expected device days.
    - (2) Multi-Drug Resistant Organism (MDRO) LabID event measures (*Clostridioides difficile* [C. diff] infections, *Methicillin-resistant Staphylococcus aureus* [MRSA], *Vancomycin-resistant Enterococcus* [VRE bacteremia], *Carbapenem-resistant Enterobacteriaceae* [CRE]):
      - (a) Standardized Infection Ratio.



Providence Little Company of Mary Medical Center Torrance

2024 Infection Prevention Program Plan

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(3) Procedure-associated HAI Infections:

(a) Standardized Infection Ratio.

**IV. Environment**

A. PLCMMCT HAS DEVELOPED SPECIFIC POLICIES AND PROCEDURES TO ADDRESS THE HOSPITAL ENVIRONMENT, INCLUDING:

1. Ventilation, temperature, humidification, and water control issues, including measures taken to maintain a safe environment during internal or external construction or renovation.
  - a) Performing Infection Control Risk Assessments (ICRA) prior to renovation, construction, or planned interruption of the utility system within the patient care environment. [CMS 482.42]
  - b) ICRAs are to be approved by an Infection Preventionist and Plant Operations and Maintenance personnel with input from unit/department managers as appropriate.
  - c) Rounds of the construction/renovation site are conducted to evaluate compliance with ICRA requirements. The IPB committee and Infection Preventionists have the authority to stop any project that is out of compliance with the requirements.
  - d) Prior to beginning any construction or renovation, the Infection Prevention department reviews the final design.
2. Maintaining safe air handling systems in areas of special ventilation such as operating rooms and airborne isolation rooms (see Plant Operations Policies).
3. Techniques for safely cleaning and disinfecting the environment.
4. Textile reprocessing, storage, and distribution.
5. Sterile processing and evaluation of failures.
6. Storage and disposal of regulated and non-regulated waste.
7. Pest or vector control.

**V. Caregiver Health**

The Caregiver Health program reduces the risk of disease transmission among healthcare workers, Licensed Independent Practitioners (LIPs), contract workers, students, and volunteers. [H&SC 1288.7; IC.02.03.01, CMS 482.24(a) (1)]

- A. The caregiver health program includes processes for health screening, childhood illness/immunization, tuberculosis screening, immunization for hepatitis B and influenza, and evaluation and assessment of post-exposure follow-up.
- B. The IPB Committee reviews and approves all policies and procedures developed in the

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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caregiver health program that relate to the transmission of infections in the hospital. The Blood-borne Pathogen Exposure Control Plan and the Aerosol Transmissible Disease Exposure Control Plan are both reviewed annually.

- C. At the time of initial employment, all employees have a baseline health screening, which includes the following:
  - 1. Medical history, including immunization status, and assessment for conditions that may predispose personnel to acquiring or transmitting communicable diseases.
  - 2. Tuberculosis screening.
  - 3. Screening for vaccine-preventable diseases.
- D. Employees are offered appropriate immunizations for communicable diseases based on regulatory requirements and the California Occupational Safety and Health Administration (Cal/OSHA), or Advisory Committee on Immunization Practices (ACIP) recommendations for healthcare workers.
- E. The Influenza Vaccine Program for employees is provided on-site without charge. If a caregiver declines the vaccination, a declination statement is obtained to gather information regarding areas of improvement within the vaccine program. Influenza vaccination rates are calculated using the CDC and National Quality Foundation (NQF) performance measure evaluation criteria. Physicians, LIPs, and volunteers are included in the influenza vaccination program, and their compliance is reviewed.
- F. The caregiver health program has policies and procedures for the evaluation and/or referral of ill employees, including assessment of disease communicability, indications for work restrictions, and management of employees, LIPs, students and volunteers who have been exposed to infectious diseases, to include post-exposure prophylaxis and work restrictions.
- G. The caregiver health program tracks immunizations and tuberculosis screening.
- H. Infection Prevention personnel are freely available to the caregiver health program for consultation regarding exposures or infectious disease concerns.

## VI. Mitigation of Infection Risks

The ministry has developed specific policies and procedures that address the following:

### A. PATIENTS WITH INFECTIONS PRESENT ON ADMISSION:

- 1. Measures are in place for early identification of patients who require isolation, per CDC guidelines.
- 2. Respiratory hygiene and cough etiquette are encouraged for everyone, beginning at the entrances to the hospital and outpatient settings. Employees are urged to discourage ill family members from visiting.
- 3. Appropriate personal protective equipment is available for all healthcare workers and visitors.



**Providence Little Company of Mary Medical Center Torrance**

**2024 Infection Prevention Program Plan**

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**B. INVASIVE PROCEDURES OR DEVICE-RELATED RISKS FOR INFECTION:**

1. Surgery-related infection policies related to antibiotic prophylaxis, surgical prep, aseptic practices, and sterilization of instruments.
2. Central line policies dictating insertion, care, and maintenance of a central line in addition to the use of bundles for prevention and the removal of unnecessary lines.
3. Ventilator policies encouraging the use of bundles for infection prevention.
4. Urinary catheter policies establishing insertion, care, and maintenance of indwelling catheters, removal of unnecessary lines, and the use of prevention bundles.

**C. OTHER HOSPITAL INFECTION RISK MITIGATION MEASURES INCLUDE:**

1. Promotion of hand hygiene among staff, employees, and visitors.
2. Protocols to prevent infections caused by resistant organisms.
3. Isolation precautions.
4. Use of disinfectants, antiseptic agents, and germicides according to manufacturers' instructions.
5. Appropriate use of medical equipment, portable air filtration equipment, and treatment booths.

**VII. Intervening Directly to Prevent Transmission of Infectious Diseases**

- A. Infection Prevention personnel review microbiology and laboratory results in addition to line lists to identify unusual clusters or higher incidences of certain microorganisms.
- B. Baseline surveillance data (historic trends) are used to determine if an outbreak is occurring. When an outbreak occurs, the Infection Prevention team seeks resources and authority to ensure a comprehensive and timely investigation in conjunction with implementation of appropriate control measures.

**VIII. Education and Training of Caregivers [IC.02.01.01]**

- A. Infection Prevention educational support is available to caregivers, LIPs, contract workers, students, and volunteers upon hire and annually through ongoing educational opportunities.
- B. Infection Preventionists, with knowledge of epidemiology and infectious diseases, actively participate in the planning and implementation of educational programs.
- C. Educational programs are evaluated periodically for effectiveness with attendance records kept by individual departments. Infection Prevention maintains records for department specific presentations. Unit Managers document ongoing in-services provided for their caregivers.
- D. The goal of the educational programs is to meet the department/group needs and to provide learning opportunities for staff, tailoring them to a wide range of educational backgrounds and



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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work responsibilities.

- E. Education and in-service recommendations specifically designed for physicians are organized through the Medical Staff Office Continuing Medical Education representative.
- F. The Infection Prevention personnel serve as consultants to staff, physicians, LIPs, patients, families, volunteers, students, and visitors regarding risks and risk reduction measures associated with disease transmission and benefits of control measures.
- G. Infection Prevention provides informal education and serves as a consultant to the staff during environmental rounds.
- H. The Infection Preventionists participate in new employee orientation and annual updates by developing, reviewing, and selecting appropriate materials.
- I. Department-specific in-services are prepared and presented by the Infection Prevention team.
- J. Infection Prevention continually performs just-in-time education during rounds and in response to inquiry.

#### **IX. Education of Patients [NPSG.07.04.01 – 07.06.01]**

- A. Infection Preventionists provide educational and informational materials to support patient education on Infection Prevention topics.
- B. The hospital provides patients with information regarding Infection Prevention measures for CDC hand hygiene practices, respiratory hygiene practices, and contact precautions, according to the patient's condition.
- C. Surgical patients are provided education by the caregivers on measures to be taken to prevent surgical infections.
- D. Patients who require a central line are provided education by the caregivers on how to prevent central line-associated bloodstream infections.
- E. Patients who require a urinary catheter are provided education by the caregivers on how to prevent catheter-associated urinary tract infections.
- F. Patients identified with multi-drug resistant organisms or C. diff are provided instructions regarding precautions to prevent the spread of the infection to others by their caregivers. [Health & Safety Code Sections 1255.8 & 1288.55].

#### **X. Reporting Systems**

##### **A. INFECTION CLASSIFICATION AND ANALYSIS:**

- 1. A database of HAIs is maintained as part of Infection Prevention surveillance.
- 2. An intensive review is performed when appropriate. HAIs that could possibly qualify as sentinel events are reported to Risk Management and to the Quality Department.

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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3. A list of employee exposures and sharps injuries is maintained by the Caregiver Health office and reviewed periodically by Infection Prevention.

#### B. PUBLIC HEALTH REPORTING:

1. Disease cases are reported as required to CDPH as well as unusual events or clusters. The Infection Prevention department maintains an Infection Line List in which significant infections are recorded. [CMS 482.42(a)(2)] [CCR Title 17].
2. Reports of suspected or known tuberculosis patients are made to LA TB Control. Infection Prevention personnel maintain contact with the case management department to support required approval of the patient's discharge plan.
3. Reports of infection-related unusual events are made to LACDPH as appropriate in conjunction with hospital leadership.
4. The occurrence of communicable diseases among patients is reviewed with the IPB Committee quarterly.
5. Mandated reporting on select HAIs is performed via NHSN in compliance with state and federal directives.
6. In conjunction with Risk Management, the Infection Prevention Department complies with Food and Drug Association (FDA) requirements to report communicable diseases associated with human cells, tissues, and cellular and tissue-based products (HCT/PS). (Based on FDA 21 CFR Part 1271).

## XI. Emergency Management [IC.01.06.01]

As part of emergency management activities, PLCMMCT/TCC is prepared to respond to an influx, or the risk of an influx, of potentially infectious patients.

#### A. THE ORGANIZATION PLAN FOR A POTENTIAL SURGE UTILIZES THE FOLLOWING PROCEDURES:

1. Emergency Management Plan.
2. Communicable Diseases; Influx of Infectious Patients.
3. Outbreak Investigation.
4. Isolation Policies.
5. Hospital's Plan for Provision of Care.
6. Pandemic Influenza and Seasonal Influenza.
7. Bioterrorism Agents Exposure Control Plan.

#### B. THE ORGANIZATION UTILIZES EXTERNAL RESOURCES TO PREPARE FOR DISASTER:

1. Infection Prevention personnel remain current with information about the emergence of

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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epidemics or new infections through California Health Alert Network (CAHAN), CDPH alerts, CDC and APIC alerts, and email and fax alerts from the Local Health Officer.

2. Infection Preventionists disseminate critical information to staff and other key practitioners verbally as well as through hospital intranet, email, flyers, and alternative methods of communication such as hand-held radios.
3. The facility participates in the local public health's "Redinett" system; staff review email alerts on issues identified in Los Angeles County area Emergency Departments.
4. The facility participates in state and local disaster drills.

#### **XII. Transitional Care Center (TCC)**

- A. The TCC has 115 licensed beds and offers transitional care for patients after leaving the hospital, skilled nursing facility, or other healthcare facilities. Patients come from different facilities around the South Bay, including PLCMMCT and Torrance Memorial.
- B. TCC has its own executive leadership team and receives support from the Executive Leadership Team from the main acute care hospital. The manager of Infection Prevention oversees Infection Prevention activities at TCC.
- C. Infection Prevention uses NHSN and McGeer definitions when performing surveillance and identifying HAIs. The Infection Preventionist at TCC uses Epic and other resources when performing this surveillance. Infections are tracked and are reported quarterly at the IPB meetings.
- D. Education is provided to patients and family members in isolation by the Infection Preventionist and staff. Caregivers are regularly in-serviced on Infection Prevention topics, including isolation precautions, hand hygiene, and prevention of HAIs.



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

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#### Resources

##### E. REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology, Text of Infection Control and Epidemiology, Online Copy Right 201021.
2. California Department of Public Health (CDPH) AFL 09-07 and 13-03.
3. CDC Guidelines as listed in document.
4. Centers for Medicare and Medicaid Services (CMS) Conditions of Participation.
5. FDA – 21 CFR Part 1271 ([www.fda.gov/cber/tissue/docs.htm](http://www.fda.gov/cber/tissue/docs.htm))
6. Health & Safety Code Sections 1255.45 & 1288.95
7. Health & Safety Code Sections 1255.8 & 1288.55
8. Health & Safety Code Sections 1255.5 & 1288.9
9. McGeer. Definitions of infection surveillance in long-term care facilities, 2012.

##### F. EVIDENCE-BASED GUIDELINE AND RECOMMENDATION ORGANIZATIONS

1. Centers for Disease Control and Prevention (CDC)
2. Association for Professionals in Infection Control and Epidemiology (APIC)
3. Society for Healthcare Epidemiology of America (SHEA)
4. The Joint Commission (TJC)
5. Occupational Safety and Health Administration (OSHA)
6. Association of Perioperative Registered Nurses (AORN)
7. California Department of Public Health (CDPH)
8. Los Angeles County Department of Health (LACDH)
9. Center for Medicare/Medical Services (CMS)

**Providence Little Company of Mary Medical Center Torrance**

**2024 Infection Prevention Program Plan**

**XIII. Comprehensive Infection Prevention Surveillance Plan**

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
<b>EPIDEMIOLOGICAL SIGNIFICANT ORGANISMS</b>	<p>Monitor Multi-Drug Resistant Organism (MDRO) NPSG 07.03.01, Health &amp; Safety Code Sections 1288. &amp; 1288.95</p> <p>CMS Conditions of Participation 482.42</p> <p>Risk for transmission among patients, employees, and visitors</p>	<p>Continuous review of all positive cultures is performed by Infection Prevention Department. Surveillance for Healthcare Associated Infections (HAIs), significant organisms, and diseases is shared with hospital leadership and key stakeholders for review.</p> <p>Reported quarterly to Infection Prevention Committee</p>
<b>Resistant Bacteria</b>		
<p>Methicillin-Resistant Staphylococcus Aureus (MRSA)</p> <p>Vancomycin Resistant Enterococcus (VRE)</p> <p>Resistant Acinetobacter</p> <p>Extended Spectrum Beta Lactamase (ESBL)</p> <p>Resistant Gram Negatives</p> <p>Carbapenem-Resistant Enterobacteriaceae (CRE)</p>	<p>MRSA and VRE Bloodstream infections – Health and Safety Code sections 1288. &amp; 1288.95</p> <p>CDPH requires reporting to NHSN LabID method.</p> <p>Active Surveillance Cultures (ASC) for MRSA required per CDPH Health &amp; Safety Code Sections 1288 &amp; 1288.95</p> <p>All CRE events reported to LACDPH and NHSN</p> <p>Risk of transmission to patients, employees, and visitors</p>	<p>Monitor for outbreaks or increase in incidence hospital-wide and/or specific units.</p> <p>Active Surveillance Cultures (ASC) for MRSA:</p> <ul style="list-style-type: none"> <li>- ICU admissions</li> <li>- Readmissions within 30 days</li> <li>- SNF admissions</li> <li>- Dialysis patients</li> <li>- Any patient with a previous history of MRSA</li> </ul> <p>Since April 2015, weekly ASCs performed for ERCP and EUS scopes and reported to System office.</p> <p>Case-by-case evaluation for HAI</p>
<p>Vancomycin Intermediate-Resistant Staph Aureus (VISA)</p> <p>Vancomycin Resistant Staph Aureus</p>	<p>Reportable to LACDPH</p> <p>Risk of transmission to patients, employees, and visitors</p>	<p>Monitor microbiology cultures to detect emergence of these pathogens</p>
<b>Unusual Or Significant Organisms</b>		
Aspergillus, Legionella, Listeria	<p>Report clusters/outbreaks to LAC DPH</p> <p>Risk of transmission to patients, employees, and visitors</p>	<p>Monitor for outbreaks or increase in incidence within community or as a hospital-acquired pathogen. Case-by-case evaluation for HAI</p>
<p>MRSA, VRE, and CRE LabID Events</p> <p>MRSA bloodstream central line infections</p> <p>VRE bloodstream central line infections</p>	<p>Use LabID method to enter in NHSN.</p> <p>Report to CDPH and CMS</p> <p>Risk for poor patient outcome</p>	<p>Ongoing monitoring of cultures for MRSA and VRE in the blood. Case-by-case evaluation for HAI</p>
Clostridioides difficile infection	<p>Health and Safety Code sections 1288. &amp; 1288.95</p> <p>CDPH and CMS requires reporting to NHSN using NHSN LabID method.</p> <p>Risk for transmission to patients, employees, and visitors.</p>	<p>All positive, non-duplicate positive C. difficile lab results are entered into NHSN. The NHSN algorithm determines community versus hospital onset.</p> <p>Monitor the number of cases, rate, and SIR of hospital onset.</p> <p>All hospital onset cases reviewed at</p>



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
Emerging Pathogens: - Measles - Pertussis - Ebola - Monkeypox - MERS - Zika Virus - Candida auris - SARS	Report cases to LAC DPH.  Risk of transmission to patients, employees, and visitors.	interdisciplinary drilldowns.  Monitor for cases.
<b>Special Investigations</b>		
All epidemiologically significant infections are investigated	CDPH requires reporting of diseases to LAC DPH  Prevent transmission of infections among patients, LIPS, and staff	Cases-by-case evaluation  Reported to Public Health as applicable
Outbreaks of infectious diseases	The Joint Commission (TJC) IC.02.01.01	Once a cluster or outbreak is identified, it is confirmed with Infectious Disease Physician and/or LACDPH
<b>Reportable Disease Surveillance</b>		
List of reportable diseases is posted on LAC DPH website and in the Infection Prevention Manual	California Code No 17 and CDPH Reportable diseases and pathogens are sent to local health department	Monitor admissions and ED visits for trends or community-onset infection or diseases
<b>HEALTHCARE ASSOCIATED INFECTIONS SURVEILLANCE (HAI)</b>	Joint Commission IC.02.01.01 CMS Conditions of Participation 482.42	Ongoing review of all positive cultures is performed by Infection Prevention Department for surveillance of HAIs, which are then provided to executive leadership, individual unit managers, and quarterly to the Infection Prevention/Blood Committee.
<b>Central Line Associated Blood Stream Infection (CLABSI)</b>		
CLABSI surveillance is ministry wide. Data analysis reports are pulled from NHSN.	NPSG 07.04.01 CLABSI Health and Safety Code sections 1288 & 1288.95  High potential for adverse outcomes	Benchmarks are from NHSN, CMS, and Providence Health System. Tracking and trending are done ministry-wide  Every CLABSI is reported to the corresponding unit and investigated.
<b>Ventilator Associated Event (VAE)</b>		
VAE surveillance in critical care units was suspended in 2020 due to the COVID-19 pandemic.	High potential for adverse patient outcomes.  Device related infection risk	No CDC benchmark for VAE comparison for adult ICUs  CDC Benchmark Pooled Mean used for ICU and NICU
<b>Catheter Associated Urinary Tract Infections (CAUTI)</b>		
CAUTI surveillance is ministry wide.  Infections that meet the CDC surveillance definition are entered into NHSN.	NPSG 07.04.01 – 07.06.01  Health and Safety Code sections 1288 & 1288.95  Device-related infection risk	Benchmarks are from NHSN, CMS, and Providence Health System. Tracking and trending are done ministry-wide  Every CAUTI is reported to the corresponding unit and investigated at multidisciplinary drilldowns
<b>Surgical Site Infections (SSI) HAI</b>		
SSI surveillance is ministry wide.	NPSG 07.05.01 SSI	SSIs are found by reviewing



## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
<p>All SSIs are reviewed and documented for trending.</p> <p>Procedures mandated for reporting by CDPH are tracked and SSI data is entered in NHSN.</p> <p>Denominator data and events are entered into NHSN.</p> <p>SSI is linked to the date of surgery in NHSN</p>	<p>CDPH requires denominator data on 29 surgical populations or procedure codes.</p> <p>CDPH requires deep and organ space surgical site infections to be reported to the state using NHSN.</p> <p>Superficial surgical site infections are collected and reported internally.</p> <p>EPIC report is used to collect surgical information.</p> <p>High potential for adverse patient outcome</p>	<p>readmissions, wound cultures notification from another hospital, notification from a unit, and EPIC surgery readmission/repeat surgeries report.</p> <p>NHSN SIR is utilized and trended over time.</p> <p>All SSIs are reported to the corresponding medical staff committee and at multidisciplinary drilldowns.</p> <p>All SSIs are reviewed to determine if there are clusters of infections related to surgeon, service, pathogens, product etc.</p>
<b>Sentinel Event Surveillance</b>		
Sentinel Event Surveillance	<p>The Joint Commission (TJC) defines a sentinel event as a patient safety event that reaches a patient and results in death, permanent harm, or severe temporary harm, and intervention is required to sustain life</p>	<p>Ongoing surveillance for any possible HAI-related sentinel events. HAI related deaths are identified by Patient Safety Program Manager South Bay</p> <p>Refer identified cases to Risk Management</p>
<b>ENVIRONMENTAL MONITORING</b>	<p>The Joint Commission (TJC) IC.02.02.01</p> <p>Minimize the risk of transmitting infections associated with the use of procedures, medical equipment, and medical devices</p>	<p>Verify compliance with Infection Prevention program via just-in-time education performed when deficiencies identified</p> <p>Reports regularly to Infection Prevention/Blood Committee</p>
<p>Hand Hygiene and personal protective equipment surveillance</p> <p>Rates are reported as # of yes divided by number of opportunities.</p>	<p>NPSG 7.01.01 The Joint Commission (TJC) IC.01.04.01</p> <p>Improve compliance with Hand Hygiene: Goal is 95%.</p> <p>Limit unprotected exposure to pathogens throughout the hospital</p>	<p>Monthly audits are performed and tracked ministry-wide</p>
<p>Isolation Practices: Infection Prevention conducts isolation rounds</p>	<p>Minimize risk to caregivers and visitors for acquiring an HAI or pathogen</p>	<p>Confirm patients are in correct precautions.</p> <p>Just-in-time education performed when isolation sign is not correct, or if non-compliance with personal protective equipment (PPE) is observed</p>
<p>Environmental Cleaning: ATP and/or Fluorescent Environmental Testing</p>	<p>Minimize risk of transmitting infection with use of medical equipment, devices, and supplies</p>	<p>ATP/Fluorescent testing to high-touch surfaces by EVS</p> <p>Report submitted regularly to IPB Committee</p>
Environment of Care Rounds	<p>Minimize risk of transmitting infection with use of medical equipment, devices,</p>	<p>Performed on clinical units, at a minimum, every 6 months/non-clinical</p>

## Providence Little Company of Mary Medical Center Torrance

### 2024 Infection Prevention Program Plan

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
	and supplies	units annually. Managers receive list of deficiencies
Environment of Care Rounds: Dietary	Compliance with Food and Safety Code 2009  Monitoring of food preparation for safe handling of food	Compliance audit performed routinely by Infection Prevention and/or Clinical Dietician and Dietary Leadership; physical inspection rounds using the Food Safety and Sanitation Audit Tool  Education on Infection Prevention topics as needed
Environment of Care Rounds: OR	Minimize risk of transmitting infection with use of medical equipment, devices, and supplies	Physical inspection performed routinely by Infection Prevention and/or OR Leadership
Construction Rounds for compliance with Infection Control Risk Assessment (ICRA)	Reduce infection risks related to construction	Ongoing monitoring, reported to Infection Prevention/Blood Committee
Ice Machines Cleaning and Disinfecting	Reduce infection risks related to equipment	Performed per manufacturers' recommendations by Facilities and presented to Infection Prevention  Plant operations maintain documentation
Renal Dialysis Water Surveillance	Minimize risk with use of equipment, devices, and supplies	Bacteriological water surveys collected monthly by DaVita and reported to Infection Prevention/Blood Committee
Monitor Air Pressure in isolation when airborne isolation room is occupied by a patient with known or suspect airborne disease	Limit unprotected exposure to pathogens throughout the hospital  ATD Standards / Cal-OSHA	Nursing submits Plant Operations work order to conduct visible check daily while patient is in Airborne Isolation.
<b>ANTIMICROBIAL STEWARDSHIP</b>	CDPH AFL 14-36 December 2014	Real-time-ID Physician reviews antibiotic usage daily with Pharmacy Reported to Infection Prevention/Blood Committee and Antimicrobial Stewardship Program committee
Antibiogram	Antimicrobial Stewardship  Provide physician with susceptibility data using micro/pharmacy report	Microbiology and pharmacy create antibiogram annually. Ongoing monitoring by Microbiology Supervisor
<b>STERILITY ASSURANCE MONITORING AND HIGH-LEVEL DISINFECTION</b>	Reduce risk of infection related to medical devices.  Minimize, reduce and eliminate risk of infection	Ongoing monitoring. Reported to Infection Prevention/Blood Committee
Immediate Use Steam Sterilization (IUSS)  Biological Monitoring on 100% of all sterilized loads (Immediate-use and unwrapped loads)  Premature release of implantable	The Joint Commission IC.02.02.01	Ongoing monitoring. Immediate-use or unwrapped load percentages reported to Infection Prevention/Blood Committee  New escalation process for every time IUSS performed. Executive Director of Perioperative services must be notified, and Infection Prevention is notified.



Providence Little Company of Mary Medical Center Torrance

2024 Infection Prevention Program Plan

Surveillance Description	Regulatory Agency / Rational	Monitoring and Evaluation
		Documentation is kept for positive biological, recalls, breaks in quarantine and number of immediate-use or un-wrapped loads
ERCP, EUS and GI endoscope monitoring	Providence Health System (PHS)	Effective April 2015 all scopes cultured daily for 30 days then moved to weekly cultures pending recommendation from PHS.  In 2018, ATP testing was implemented for all scopes and results are reported out at the IPB meeting
<b>CAREGIVER HEALTH</b>	Prevent transmission of infections among patients, IPS and staff  CDC and Division of Occupational Safety and Health (Cal OSHA)	Data collected by Caregiver Health and reviewed by Infection Prevention
Exposures, Blood-borne		All Blood-borne pathogen exposures investigated and reported on OSHA log
Exposures, communicable diseases		All reported communicable disease exposures investigated for prophylaxis and follow-up
Influenza vaccination screening	Health & Safety Code Sections 1288.5-1288.9 requires all healthcare providers to wear a mask if they decline flu vaccination	Reported to CDPH via NHSN  Reported to Infection Prevention/Blood Committee
Employee screening for TB and conversions	CDPH	Ongoing evaluation by Caregiver Health and Infection Prevention. Reported to Infection Prevention and Blood Committee
Exposures, COVID-19	CAL/OSHA, CDC, CDPH	Ongoing evaluation by Caregiver Health and Infection Prevention. Reported to Infection Prevention and Blood Committee



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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## **BACKGROUND**

Providence Little Company of Mary Medical Center Torrance (PLCMMCT) conducts an annual infection prevention risk assessment to identify the risk of transmission and acquisition of infectious agents throughout the hospital. It pertains to patients, licensed independent practitioners (LIPs), staff, volunteers, students, visitors, and family. This risk assessment is based on the geographic location of the hospital, the programs/services provided, characteristics of the patient population served, community needs, and the results of analysis of the hospital's infection prevention data from 2023. The risk assessment is formally reviewed at least annually and whenever significant changes occur in any of these factors (IC.01.03.01).

## **SCOPE OF ASSESSMENT**

The scope of this risk assessment is ministry wide. It covers inpatient and ambulatory care settings as well as general outpatient care settings.

## **RISK ASSESSMENT INCLUDES:**

- I. Scope of Service: Geographic and Demographic Review**
- II. Current Location of Services**
- III. Patient Population Served and Clinical Focus**
- IV. Program Effectiveness: Review and Evaluation of 2023 Hospital Surveillance**
- V. Caregiver Health**
- VI. Risk Analysis for 2024 Prioritized Risks Identified**
- VII. Goals, Objectives and Strategies to Manage Risks**
- VIII. Program Effectiveness: 2023 Hospital Surveillance Review Table**
- IX. 2024 Goals and Targets From 2023 Prioritized Risk Assessment**
- X. Appendix**

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### **I. Scope of Service:**

#### **A. GEOGRAPHIC INFORMATION (IC.01.03.01)**

Providence Little Company of Mary Medical Center Torrance (PLCMMCT) is situated in a suburban area, adjacent to multiple outpatient and office facilities, interstates, a train station, and several shopping centers. Both the Los Angeles International Airport and the Port of Los Angeles are located approximately 9 miles away from the hospital. Oil refineries and the Terminal Island Prison are both within 15 miles. The Infection Prevention Plan provides for

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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the monitoring of emergency room patients and outpatients receiving services within the hospital who may arrive here due to the geographical proximity of the facility.

**B. DEMOGRAPHIC INFORMATION**

1. PLCMMCT is a licensed 327-bed, general acute care, not-for-profit facility for adults and children. The hospital provides adult and neonatal intensive care, as well as perinatal, coronary, neurological, renal, surgical, emergency, and a variety of outpatient services. People experiencing homelessness and those with mental health disorders are provided for within this facility, primarily in the emergency department.
2. PLCMMCT provides care to a diverse patient population, specifically in regard to race and religion. In 2023, there were approximately 15, 626 patients admitted, 8,243 surgeries in the OR suites, 677 C-sections in the Labor and Delivery (L&D) surgical suites, and 4,119 gastrointestinal (GI) procedures.

**II. Current Location of Services**

**A. HANNON TOWER**

Hannon Tower				
Location	Departments	Inpatient/OBS	Outpatient	Partners
4 <sup>th</sup> floor	4 West Medical	X		
4 <sup>th</sup> floor	4 Medical Cardiology	X		
3 <sup>rd</sup> floor	Labor and Delivery	X		
3 <sup>rd</sup> floor	Neonatal Intensive Care Unit	X		
3 <sup>rd</sup> floor	Newborn Nursery	X		
3 <sup>rd</sup> floor	C-Section Suites	X		
2 <sup>nd</sup> floor	Intensive Care Unit	X		
2 <sup>nd</sup> floor	Operating Room (13 suites)	X	X	
1 <sup>st</sup> floor	Volunteer Office			X
1 <sup>st</sup> floor	Surgical Orthopedics	X		
1 <sup>st</sup> floor	Emergency Department Overflow		X	
1 <sup>st</sup> floor	Respiratory Offices			X
1 <sup>st</sup> floor	Rehabilitation Services			X
Ground floor	Sterile Processing / Central Supply			X
Ground floor	Imaging	X	X	

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

Ground floor	Emergency Department		X	
Ground floor	Pharmacy			X

**B. HERITAGE TOWER**

Heritage Tower				
Location	Departments	Inpatient/OBS	Outpatient	Partners
4 <sup>th</sup> floor	Telemetry-Oncology	X		
3 <sup>rd</sup> floor	Mother Baby	X		
3 <sup>rd</sup> floor	Pediatrics	X		
2 <sup>nd</sup> floor	Progressive Care Unit	X		
2 <sup>nd</sup> floor	Same Day Surgery	X	X	
1 <sup>st</sup> floor	Medical-Surgical-Telemetry (Telemetry Oncology Unit - Overflow)	X		
1 <sup>st</sup> floor	Gastrointestinal Lab	X	X	
1 <sup>st</sup> floor	Blood Bank			X
1 <sup>st</sup> floor	Medication Management		X	
1 <sup>st</sup> floor	Health Information Services			X
1 <sup>st</sup> floor	Cafeteria			X
Ground floor	Food/Nutrition Services	X	X	X
Ground floor	Environmental Services	X	X	X
Ground floor	Clinical Engineering / Biomedical			X
Ground floor	Cardiovascular Lab	X	X	
Ground floor	Angio-Recovery	X	X	
Ground floor	Outpatient Diagnostics		X	
Ground floor	Radiology	X	X	

**C. OFF-SITE LOCATIONS**

Off-Site Locations	
Information Technology Building	Clinical Laboratory
20929 Hawthorne Blvd.	Women's Imaging & Cardio Pulmonary Rehabilitation
21135 Hawthorne Blvd.	Outpatient Rehabilitation



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

4320 Maricopa St.

Providence Transitional Care Center

### **III. Patient Population Served and Clinical Focus**

#### **A. PROVIDENCE LITTLE COMPANY OF MARY TORRANCE**

The hospital has 9 inpatient care areas. There are 327 patient beds, 15 of which are designed to admit patients with airborne diseases. Standard rooms may be designated for isolation of non-airborne diseases.

##### **1. Intensive Care Unit – ICU**

The ICU provides care for critically ill patients with a variety of conditions, including surgical, neurological, and cardiac cases. The ICU contains designated rooms for neurological surgeries and conditions as well as a separate area for cardiac patients. Surveillance is performed in the ICU for all infections, with emphasis on risks related to invasive devices, such as ventilators, central lines, and urinary catheters. Active surveillance screens for *Methicillin-resistant Staphylococcus aureus* (MRSA) are performed on all admissions. The ICU has twenty-eight (28) beds.

##### **2. Neonatal Intensive Care Unit – NICU**

The NICU provides care for critically ill infants. Surveillance is performed for all infections, with emphasis on central line associated bloodstream infections. Active surveillance screens for MRSA are performed on all admissions. Infants from Providence Little Company of Mary San Pedro may also be admitted to this unit. The NICU has thirty-four (34) beds.

##### **3. Inpatient Units: Medical-Surgical, Medical-Telemetry, Progressive Care Unit, & Pediatrics**

This population is served in six (6) different inpatient care areas. Each area is monitored separately for healthcare-associated infections (HAIs). Surveillance is performed on all infections, with emphasis on surgical sites, indwelling urinary catheters, central lines, resistant organisms, and infections reportable to Los Angeles County Department of Public Health (LACDPH). The areas of clinical focus include post-operative patients, patients with medical conditions, patients requiring telemetry, neurological patients, bariatric patients, and patients with orthopedic, gynecological, and oncological conditions. PLCMMCT does not have a dedicated unit for dialysis patients; patients are managed ministry-wide by DaVita Healthcare Partners contracted with the hospital.

##### **4. Obstetrics and Labor and Delivery**

This patient population has a low risk for infection; however, surveillance and rounding are still performed regularly. The most frequent complications are endometritis, urinary tract infections, and surgical site infections from Caesarean Section (approx. 58 C-Sections

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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are performed per month). Pertussis and Influenza vaccinations are offered to all new mothers during flu season. 677 Caesarean Sections were performed in 2023.

5. Newborn Nursery

This area is monitored for all infections, including reportable diseases to LACDPH. Most newborns reside with the post-partum mother until discharge. In 2023, approximately 2,359 births occurred at PLCMMCT.

6. Surgical Services

A variety of surgical services are performed at PLCMMCT, including neurosurgery, cardiothoracic, orthopedic, colorectal, urological, gynecological, general, and pediatric cases. 292 craniotomies were performed here as a comprehensive stroke center. 2023 data: 2,905 Inpatient surgeries; 5,338 Outpatient surgeries

7. Emergency Department

The emergency department sees a variety of patients. There are twenty-eight (28) beds with a designated room for Code Stroke and Code AMI. 2023 data: 54,945 Emergency Department visits, including patients admitted to the hospital.

8. Gastrointestinal (GI) Lab

The GI Lab provides procedures for both inpatients and outpatients. 2023 data: 4,119 procedures

**IV. Program Effectiveness: Review and Evaluation of 2023 Hospital Surveillance**

National Healthcare Safety Network (NHSN) criteria is utilized in the identification of healthcare-associated infections, including CLABSI, CAUTI, SSI, and LabID.

**A. SUMMARY OF CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)**

1. Standardized Infection Ratio (SIR) and Standardized Utilization Ratio (SUR) calculations are used to evaluate the data. The SIR is calculated by dividing the number of observed infections by the number of predicted infections; therefore a SIR greater than 1.0 indicates that more HAIs were observed than predicted.
2. A total of 6 CLABSIs hospital-wide were entered into NHSN for 2023, which is equal to 6 CLABSIs in 2022. Ministry-wide, the hospital demonstrated a SIR of 0.896, which is below the NHSN benchmark. The ministry-wide SUR was 0.596. An interdisciplinary drill down is performed on each event.
3. In 2022 a system site assessment occurred due to CLABSI rates. Blood culture collection was identified as an area of opportunity. A ministry based education program was created to improve blood culture collection technique.



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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4. See Appendix – A.

a) Figure 1: 2023 Hospital-Wide CLABSI Report

**B. SUMMARY OF CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)**

1. Standardized Infection Ratio (SIR) and Standardized Utilization Ratio (SUR) calculations are used to evaluate the data.
2. A total of 8 CAUTIs meeting the surveillance definition were reported to NHSN in 2023, which was equivalent to the previous year, 8 CAUTIs in 2022. The calculated ministry-wide SIR of 1.083 is higher than the national benchmark of 1. The ministry-wide SUR was 0.549. All events are reviewed at the interdisciplinary drill down.
3. Plans include continuing with education regarding the Nurse Driven Protocol to promote early removal of catheters. Likewise, the team continues to work to limit the amount of indwelling urinary catheters inserted in the emergency department to only those specifically indicated for acute urinary retention or obstruction. A “Buddy-System” was initiated in 2018 when inserting an indwelling catheter to aid in maintenance of aseptic technique.
4. In 2023, Stryker conducted a new product trial with Primofit, a male external urine collection device, on our Tele Oncology and Progressive Care Units. The trial was successful, and the product was rolled out ministry wide.
5. See Appendix – B.
  - a) Figure 2: 2023 Hospital-Wide CAUTI Report

**C. SUMMARY OF VENTILATOR ASSOCIATED EVENTS (VAE)**

1. VAE surveillance was suspended during the COVID-19 Pandemic and was restarted in January 2023.
2. A total of 32 VAEs meeting the surveillance definition were reported to NHSN in 2023. The ministry-wide SIR of 1.671 is higher than the national benchmark of 1. The ministry-wide SUR was 0.498.

**D. SUMMARY OF SURGICAL SITE INFECTIONS (SSI)**

1. This report includes superficial, deep, and organ space SSI meeting NHSN reportable criteria. Centers for Medicare and Medicaid Services (CMS) requires deep and organ space SSIs be identified and publicly reports colorectal and hysterectomy infections.
2. To date, a total of 21 SSIs recognized by NHSN and were included in our numerator data in 2023, compared to 18 in 2022. Of these infections, 10 were superficial, 3 were deep fascia, and 8 were organ space.
3. See Appendix – C
  - a) Figure 3: 2023 Annual Surgical Site Infections by Type Table
  - b) Figure 4: 2023 Annual Surgical Site Infections by Type Graph



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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**E. SUMMARY OF EPIDEMIOLOGICALLY SIGNIFICANT HOSPITAL-ONSET MULTI-DRUG RESISTANT ORGANISM (MDRO)**

1. There were 3 cases of hospital-onset *Methicillin-resistant Staphylococcus aureus* (MRSA) bacteremia in 2023.
2. There were 6 cases of hospital-onset *Carbapenem-resistant Enterobacteriaceae* (CRE) (all) in 2023.
3. There was 1 case of hospital-onset *Candida auris* in 2023.
4. See Appendix – D
  - a) Figure 5: Quarterly MRSA Hospital Onset, Community Onset and Surveillance Screens per 1,000 Patients Days
  - b) Figure 6: Quarterly MRSA Hospital Onset Bacteremia SIR
  - c) Figure 7: Quarterly VRE Hospital Onset, Community Onset and Surveillance Screens per 1,000 Patients Days
  - d) Figure 8: ESBL Hospital Onset, Community Onset and Surveillance
  - e) Figure 9: CRE Hospital Onset, Community Onset and Surveillance

**F. SUMMARY OF CLOSTRIDIODES DIFFICILE (C. DIFF)**

1. There were 14 cases of hospital-onset C. diff infections in 2023, with a ministry-wide SIR of 0.4, compared to 23 cases in 2022.
2. Education urging staff to isolate all patients with loose stools immediately and emphasizing testing stools upon admission to minimize the risk of transmission-based C. diff was provided throughout the year. This aids in determining the community-onset and the hospital-onset rates early. The Infection Prevention department instructs to isolate any diarrhea of unknown origin, regardless of the presence of C. diff, to protect patients, staff, and visitors.
3. In 2023, Infection Prevention created a new policy, Clostridioides Difficile Active Surveillance Screening, that allows the nurses to order C diff for screening in the first three days of admission. The C diff algorithm was also updated and re-released at that time.
4. The Environmental Services caregivers utilize fluorescent testing and ATP testing to evaluate cleaning effectiveness. Environmental Services follows policy and procedures for best practice.
5. See Appendix – D
  - a) Figure 10: *Clostridioides difficile* Hospital Onset, Community Onset and Surveillance; and C. diff SIR graph

**G. HAND HYGIENE COMPLIANCE**

The hand hygiene compliance rate for 2023 was 96 percent hospital-wide. Each unit must complete a minimum of thirty (30) audits each month on varying shifts.

**H. INFLUENZA and COVID-19 IMMUNIZATION PROGRAM COMPLIANCE**

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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All employees of PLCMMCT are encouraged to receive annual influenza and COVID-19 vaccinations. Caregiver Health provides education to all staff to encourage vaccine compliance using multiple modalities. Total participation in the Flu program was at 93.0 percent for the 2022-2023 season (71.3% acceptance rate and 21.6% declination). Total participation in the COVID program was 93.6 percent in 2023 (includes dose 1 and 2 of a two-dose series or 1 dose for completion).

**V. Caregiver Health**

- A. Caregiver Health works collaboratively with the Infection Prevention Department to minimize the spread of infectious disease to and from employees. The number of employees that Caregiver Health has oversight for includes:
  - 1. Providence Little Company of Mary Torrance = 2,213 caregivers
  - 2. Volunteers = approximately 88
- B. Caregiver Health Services contribute to the prevention and control of communicable diseases by established policies and procedures, listed below:
  - 1. Pre-placement health evaluation and health screen; laboratory analysis of rubella and rubeola titers, varicella history/varicella titer, hepatitis B and C titers if indicated, and tuberculosis screening. N95 respiratory fit testing and/or Powered Air Purifying Respirator (PAPR) training and education is provided for specific job categories, determined by a risk assessment conducted by Infection Prevention.
  - 2. An annual Employee Health assessment update and tuberculosis screening for all caregivers.
  - 3. Immunization programs for vaccine preventable infections including varicella, rubella, rubeola, hepatitis B, influenza, and pertussis for all appropriate caregivers.
  - 4. COVID-19 immunization implemented in 2020.
  - 5. Immediate assessment and care for caregivers with a work-related exposure. This includes blood and body fluid incidents, active tuberculosis exposures, pertussis, bacterial meningitis, etc.
  - 6. Investigating and monitoring exposures to communicable disease and illness.
  - 7. Establishing proactive policies and procedures for management of caregiver infection risks related to disasters, bioterrorism, and emerging pathogens.
  - 8. Establishing guidelines for work restrictions due to communicable disease.
  - 9. Maintaining caregiver health record.



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

**VI. Risk Analysis for 2024 Prioritized Risks Identified, Based on 2023 Outcomes**

Risk Issue/ Incident Settings  Including Inpatient, Outpatient, & Ambulatory unless specified.	Has incident occurred in past 12 mos.? (Yes/No)	Prevention or Control Strategy in place (Yes/No)	Probability of event occurrence in next 12 mos. 1=low 2=med 3=high	Potential Impact on patients or facility 1=low 2=med 3=high	Risk Score = Probability plus Potential Impact	Priority Rank H-High M-Med L-Low
<b>Device or Procedure related Risks</b>						
Central line BSI – Inpatient	Yes	Yes	3	3	6	H
Ventilator Associated Event – Inpatient (IVAC/PVAP)	Yes	Yes	3	3	6	H
Catheter related UTI – Inpatient	Yes	Yes	3	3	6	H
Surgical Site Infection – Inpatient	Yes	Yes	3	3	6	H
<b>Equipment Related Risks</b>						
Sterilization of medical devices (failure)	No	Yes	1	3	4	M
High Level Disinfection medical devices (failure)	No	Yes	1	3	4	M
IUSS	No	Yes	1	3	4	M
Cleaning of common equipment between patients (failure)	No	Yes	2	2	4	M
<b>Pathogen Exposure Risks for Employees and Visitors</b>						
MDROs (CRE, MRSA, VRE, ESBL, <i>C. auris</i> etc.)	Yes	Yes	2	3	5	M
Clostridium Difficile	Yes	Yes	3	2	5	M
Influenza – Seasonal	Yes	Yes	2	3	5	M
Pertussis	No	Yes	2	1	3	L
COVID-19	Yes	Yes	3	2	5	M
Tuberculosis	Yes	Yes	3	2	5	M
<b>Internal Environmental Risks</b>						
Construction or Renovation Projects	No	Yes	2	2	4	M
Repairs/Maintenance that affect patient care areas	No	Yes	2	2	4	M
Laundry and linen problems	Yes	Yes	2	3	5	M
Medical waste mishandling	No	Yes	2	2	4	M
Water intrusion/Disruption	Yes	Yes	3	2	5	M
Environmental cleanliness – terminal cleaning failure	No	Yes	1	2	3	L
Environmental cleanliness – terminal cleaning of surgical/ procedure areas	No	Yes	1	3	4	M
Environmental cleanliness – ventilation system	Yes	Yes	3	2	5	M
Safe Food Handling: cool down logs, labeling	No	Yes	2	3	5	M
Ice Machines – Schedule for cleaning ice container in kitchen	No	Yes	1	2	3	L
<b>Employee Related Risks</b>						
Hand Hygiene (non-compliance)	Yes	Yes	3	3	6	H
PPE (non-compliance)	Yes	Yes	3	2	5	M



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

Risk Issue/ Incident Settings Including Inpatient, Outpatient, & Ambulatory unless specified.	Has incident occurred in past 12 mos.? (Yes/No)	Prevention or Control Strategy in place (Yes/No)	Probability of event occurrence in next 12 mos. 1=low 2=med 3=high	Potential Impact on patients or facility 1=low 2=med 3=high	Risk Score = Probability plus Potential Impact	Priority Rank H-High M-Med L-Low
Blood-borne pathogen exposure such as needle-stick injuries and splashes	Yes	Yes	3	2	5	M
Unidentified TB/respiratory illness patients in Emergency Department & direct admission	Yes	Yes	3	3	6	H
<b>External Environment Risks</b>						
Community outbreaks of communicable diseases with influx of infectious patients (Ebola, RSV, Measles, COVID-19, novel pathogens)	Yes	Yes	3	3	6	H
<b>Other Infection Prevention Related Activities</b>						
Compliance with NPSG, TJC, CDPH, CMS	Yes	Yes	2	3	5	M
Mandatory reporting and use of NHSN	No	Yes	1	2	3	L
Priority Rank Key: Low = 1-3 Med = 4-5 High = 6						

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

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**VII. Goals, Objectives, and Strategies to Manage Risks**

- A. Using the risk analysis and the summary of HAI surveillance outcomes, prioritized risks are identified. Certain risks are automatically prioritized based on their nature, scope, and impact on the care, treatment, and services provided.
- B. Goals and objectives with specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure, surveillance and monitoring activities, education and training programs, environment and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application and/or duration depending on the specific risk issue, the care setting(s), and environment involved.
- C. The following table lists the prioritized risks identified from the Infection Prevention and Blood Committee. The table provides a brief description of those risks and outlines, in summary form, strategies that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of action taken.

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

**VIII. Program Effectiveness: 2023 Hospital Surveillance Review Table**

Prioritized Risk	Goal	Measurable Objectives	Methods / Strategies	Measurement	OUTCOMES								
<p>Hand hygiene – lack of compliance poses risk of pathogen transmission to patients and staff</p> <p>Regulatory requirement: IC.01.04.01</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>Yes</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	Yes	Improve compliance with hand hygiene – improve method of hand washing	Increase compliance PHS Goal – 90%	<p>Education at new hire</p> <p>Hand sanitizer available in all In-patient, Outpatient and Ambulatory units and waiting areas,</p> <p>Cipher HH audit tool</p>	Direct observation is the method used for collecting data. This is performed by the Infection Prevention Dept. or designated observer for Inpatient units. Results shared with managers and reviewed at Infection Prevention Committee	96% compliance with hand hygiene <b>TARGET MET</b> with current hand hygiene process.
Setting													
Inpatient	Yes												
Outpatient	Yes												
Ambulatory	Yes												
<p>Potential for the transmission of MDROs and C. Diff among patients, staff and visitors due to practices relating to cleaning of equipment and environment</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	No	<p>Improve cleaning and disinfection of movable equipment</p> <p>Improve hand hygiene compliance</p>	<p>Reduction in MDRO</p> <p>ATP Environmental testing reports</p> <p>Ministry goal &lt;19 cases of <i>C. diff</i></p> <p>HH Compliance</p>	<p>EVS trained on isolation and terminal cleaning. Staff encouraged to use disinfectant wipes for all surfaces especially for high touch areas in patient rooms</p> <p>EVS policies for cleaning and disinfecting rooms with hospital grade disinfectant. Review regional movable equipment policy and ensure it is operational</p>	<p>MDRO Surveillance statistics</p> <p>Environmental rounding</p> <p>NHSN MRSA and VRE bacteremia SIR</p>	<p><b>TARGET MET FOR MRSA/VRE</b></p> <p><b>TARGET MET FOR C DIFF</b></p>
Setting													
Inpatient	Yes												
Outpatient	Yes												
Ambulatory	No												
<p>Infections associated with the use of invasive devices. CLABSI and CAUTI IC.01.04.01</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>No</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	No	Ambulatory	No	Minimize infection risk associated with invasive devices	<p>Decrease device associated infections and Standardized Utilization Ratios (SUR); decrease Standardized Infection Ratios (SIR) less than 1</p> <p>PSJH Targets: CLABSI – 2 CAUTI – 3</p>	<p>Teaching and monitoring evidenced-based bundles for prevention of CLABSI and CAUTI</p> <p>Monthly bundle compliance audits.</p> <p>Clinical orientation addresses prevention measures</p> <p>Standard work for central line dressing changes</p>	<p>Infection Prevention tracks and trends data and enters infections and denominators into NHSN</p> <p>SIR and SUR are pulled from the NHSN databank</p> <p>CAUTI and CLABSI prevention bundle audits</p>	<p>Total of 6 CLABSI, SIR .896 and PSJH <b>TARGET NOT MET</b></p> <p>Total of 8 CAUTI, SIR 1.083 and PSJH <b>TARGET MET</b></p>
Setting													
Inpatient	Yes												
Outpatient	No												
Ambulatory	No												
<p>Potential for surgical site infections related to operative procedures</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>No</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	No	Ambulatory	No	Minimize infection risk associated with surgeries	<p>Decrease surgical site infections to SIR less than 1</p> <p>PSJH Targets: HYST SIR – 0</p>	<p>SSI drill down with all units involved to examine opportunities for improvement</p> <p>HYST Bundles implemented</p>	<p>Infection Prevention tracks and trend data and enters infections into NHSN. SIR is pulled from the NHSN databank</p>	<p>SSI HYST SIR – 0.743 <b>TARGET MET</b></p>
Setting													
Inpatient	Yes												
Outpatient	No												
Ambulatory	No												



**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

**IX. 2024 Goals and Targets From 2023 Prioritized Risk Assessment**

Prioritized Risk	Goal	Measurable Objectives	Methods / Strategies	Measurement								
<p>Infections associated with the use of invasive devices. CLABSI and CAUTI. IC.01.04.01</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>No</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	No	Ambulatory	No	<p>Minimize infection risk associated with invasive devices</p>	<p>Decrease device associated infections and Standardized Utilization Ratios (SUR); Decrease Standardized Infection Ratios (SIR) less than 1</p> <p>PSJH Target: CAUTI: .6626 CLABSI: .4829</p>	<p>Teaching evidenced based bundles for prevention of CLABSI and CAUTI. Drill down with all units involved for improvement opportunities.</p> <p>Biweekly bundle audits</p> <p><b>Standard work</b> for central line dressing changes. Standard work for catheter insertion</p>	<p>SIR and SUR are tracked from the NHSN databank against targets</p> <p>CAUTI and CLABSI prevention bundle audits</p>
Setting												
Inpatient	Yes											
Outpatient	No											
Ambulatory	No											
<p>Potential for surgical site infections related to operative procedures</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>No</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	No	Ambulatory	No	<p>Minimize infection risk associated with surgeries</p>	<p>Decrease HYST surgical site infections to SIR less than 1</p>	<p>SSI drill down with all units involved as identified to examine opportunities for improvement</p> <p>HYST Bundle continued utilization</p>	<p>SIR is tracked from the NHSN databank against targets</p>
Setting												
Inpatient	Yes											
Outpatient	No											
Ambulatory	No											
<p>Potential for failure in sterilization, high level disinfection, and immediate use steam sterilization</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>Yes</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	Yes	<p>Eliminate occurrence of failure in sterilization, high level disinfection, and immediate use steam sterilization</p>	<p>Current rate 0.0%. Maintain IUSS rate of 0.0%. Target was met in 2023.</p>	<p>Sterile processing equipment is serviced and checked regularly</p> <p>Protocols in place in event of failure in sterilization, high level disinfection, and immediate use steam sterilization</p>	<p>IUSS occurrences reported to Infection Prevention Department and rates overseen by Infection Prevention Committee</p>
Setting												
Inpatient	Yes											
Outpatient	Yes											
Ambulatory	Yes											
<p>Potential for the transmission C. diff among patients, staff and visitors due to practices relating to cleaning of equipment and environment</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>No</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	No	<p>Cleaning of movable equipment</p> <p>Improved hand hygiene compliance</p>	<p>Reduction in C. diff</p> <p>Ministry goal &lt;17 cases</p> <p>Florescent testing reports</p>	<p>EVS trained on isolation and terminal cleaning. Staff encouraged to use disinfectant wipes for all surfaces especially for high touch areas in patient rooms</p> <p><b>EVS policies</b> for cleaning and disinfecting rooms with hospital grade disinfectant.</p>	<p>C. diff events reviewed during drill down for all HO cases</p> <p>Infection/isolation rounding</p> <p>Environmental rounding</p> <p>Florescent testing reports</p>
Setting												
Inpatient	Yes											
Outpatient	Yes											
Ambulatory	No											
<p>Potential for transmission of COVID-19 from patient to patient, patient to caregiver, caregiver to patient, or caregiver to caregiver</p> <table><tr><th colspan="2">Setting</th></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>Yes</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	Yes	<p>No transmission of COVID-19 from patient to patient, patient to caregiver, caregiver to patient, or caregiver to caregiver</p>	<p>Endemic Status</p> <p>Reduction in COVID-19 exposures</p>	<p>Following CDC, CDPH and LA DPH guidance</p> <p>Isolation for COVID-19</p> <p>Availability of sufficient equipment for nurses to maintain contact, droplet, and/or precautions</p> <p>COVID-19 vaccination</p>	<p>Isolation precautions</p> <p>COVID-19 vaccination compliance</p> <p>Review COVID-19 + results, monitor for any potential transmission</p>
Setting												
Inpatient	Yes											
Outpatient	Yes											
Ambulatory	Yes											

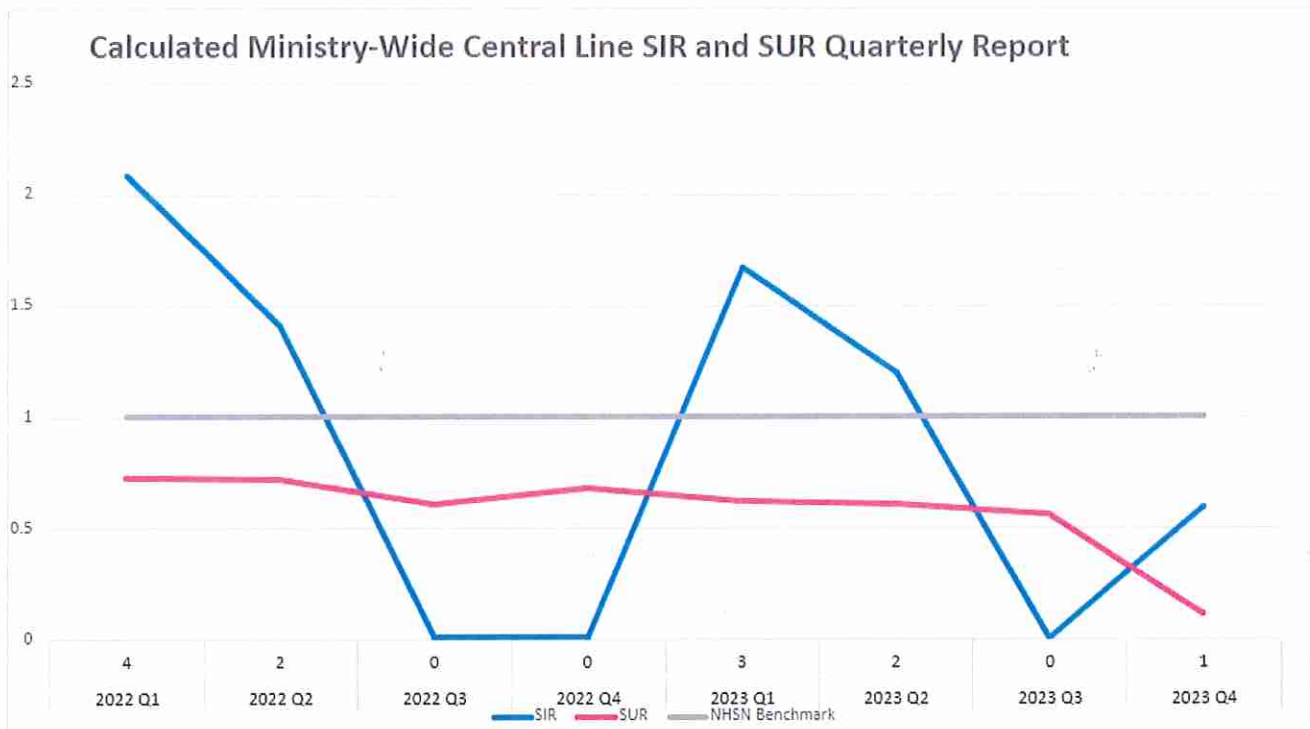
**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

Prioritized Risk	Goal	Measurable Objectives	Methods / Strategies	Measurement								
Hand hygiene – lack of compliance poses risk of pathogen transmission to patients and staff  Regulatory requirement: IC.01.04.01 <table><tr><td colspan="2">Setting</td></tr><tr><td>Inpatient</td><td>Yes</td></tr><tr><td>Outpatient</td><td>Yes</td></tr><tr><td>Ambulatory</td><td>Yes</td></tr></table>	Setting		Inpatient	Yes	Outpatient	Yes	Ambulatory	Yes	Improve compliance with hand hygiene  Improve collection method for hand hygiene audits- discrepancy between audits collected by departments and validation audit	Increase compliance PHS Goal – 95%  30 HH audits per month for each department	Education at new hire Hand sanitizer available in all In-patient, Outpatient, and Ambulatory units and waiting areas  Implement Cipher data collection tool for audits	Direct observation- overt audits  Results shared with managers and reviewed at Infection Prevention Committee
Setting												
Inpatient	Yes											
Outpatient	Yes											
Ambulatory	Yes											
Influenza – seasonal Flu program participation	Improve participation to 95% for 2023-2024 influenza season	Percent of participation	Education of vaccination clinics dates, educate on use of declination form	Caregiver health tracking via PureSafety site								

## X. Appendix

### A. APPENDIX – A

**Figure 1: 2023 Ministry-Wide CLABSI Report**



**2023 Summary:** House-wide there were 6 CLABSIs in 2023. The House-Wide SIR is .896, below the national benchmark. The Standardized Utilization Ratio (SUR) is 0.596, below the national benchmark.

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

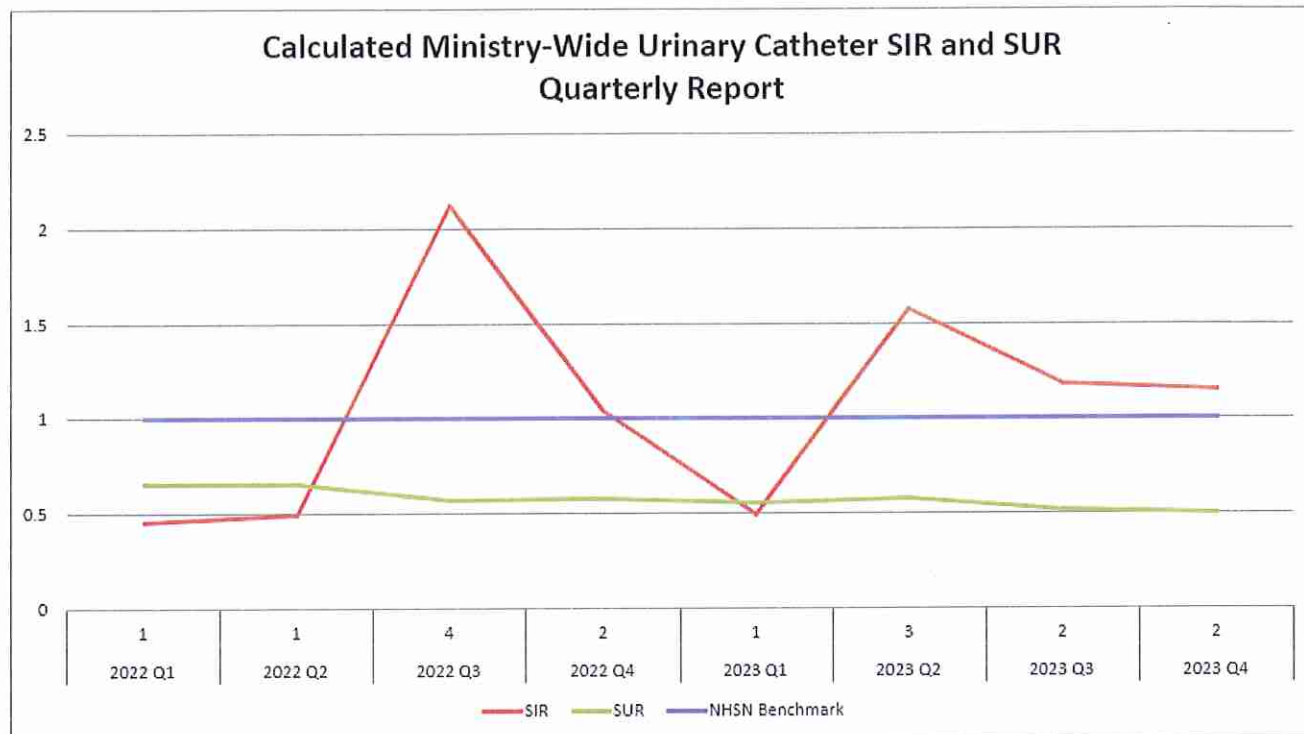
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Providence Little Company of Mary Medical Center Torrance  
2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals

B. APPENDIX – B

Figure 2: 2023 Ministry-Wide CAUTI Report



**2023 Summary:** House-wide there were 8 CAUTIs in 2023, and the system metric for CAUTI was exceeded. The House-Wide SIR is 1.083, above the national benchmark. Standardized Utilization Ratio (SUR) is 0.549, below the national benchmark.

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

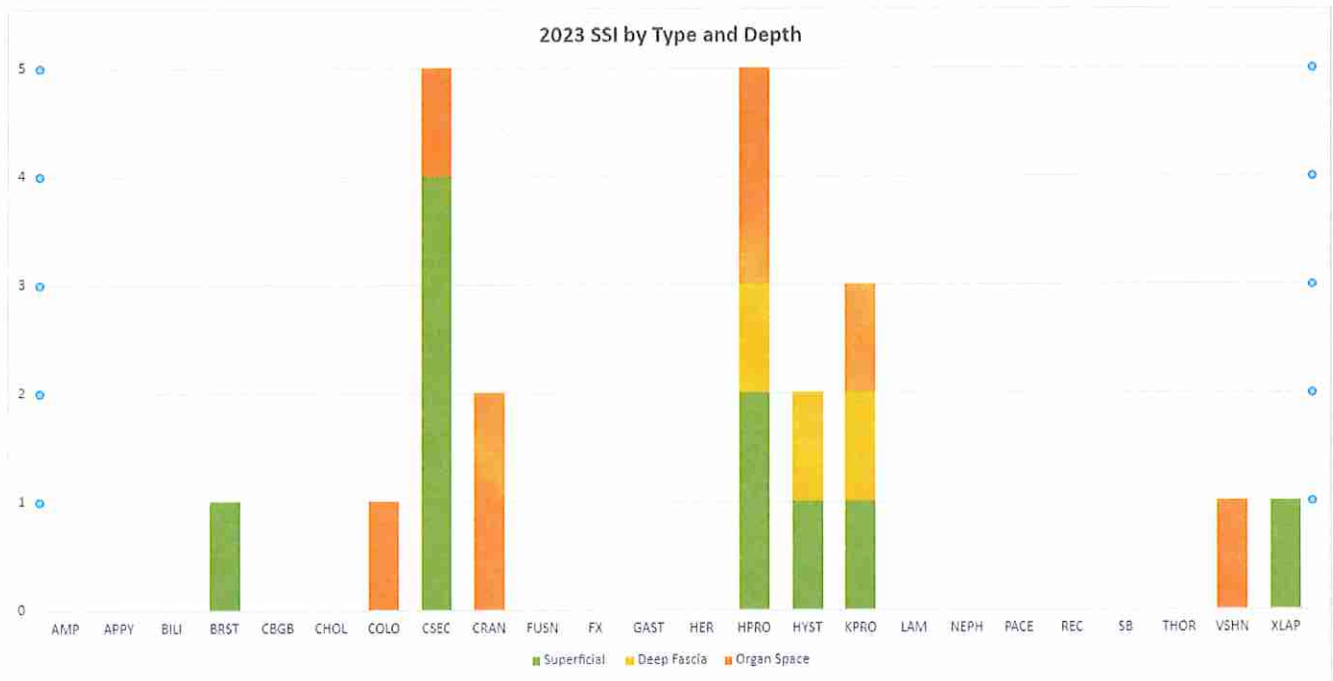
C. APPENDIX – C

**Figure 3: 2023 To-Date Annual Surgical Site Infections by Type Table**

Summary	Procedure Count	SSI Count	Expected # SSI	SIR	Note: Subject to change until 100 days after the close of the quarter		
2023	3962	11	23.27	0.473			
proccode	procCount	Infection Count	Number Predicted	SIR Complex	Superficial	Deep	Organ space
COLO	126	1	2.563	0.39			1
CRAN	292	2	2.768	0.722			2
HPRO	225	3	1.448	2.071		1	2
HYST	191	1	1.192	0.839		1	
KPRO	270	2	1.262	1.585		1	1
SB	108	1	2.126	0.47			1
VSHN	20	1	0.216				1
AAA	0	0					
AMP	65	0	0.057				
APPY	149	0	0.369				
AVSD	0	0					
BILI	8	0	0.143				
BRST	147	0	3.074	0			
CARD	84	0	0.258				
CBGB	82	0	0.508				
CBGC	0	0					
CEA	16	0	0.011				
CHOL	244	0	0.826				
CSEC	677	0	1.264	0			
FUSN	148	0	1.059	0			
FX	167	0	0.893				
GAST	55	0	0.325				
HER	87	0	0.465				
LAM	188	0	0.627				
NECK	6	0	0.067				
NEPH	16	0	0.053				
OVRV	129	0	0.087				
PACE	115	0	0.189				
PRST	10	0	0.026				
PVBY	0	0					
REC	27	0	0.2				
SPLE	2	0	0.007				
THOR	72	0	0.205				
THYR	17	0	0.014				
VHYS	5	0	0.021				
XLAP	214	0	0.946				

Providence Little Company of Mary Medical Center Torrance  
2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals

Figure 4: 2023 To-Date Annual Surgical Site Infections by Type Graph



SSI Summary 2023 YTD:

Total SSI -- 21

SIP -- 10

DIP -- 3

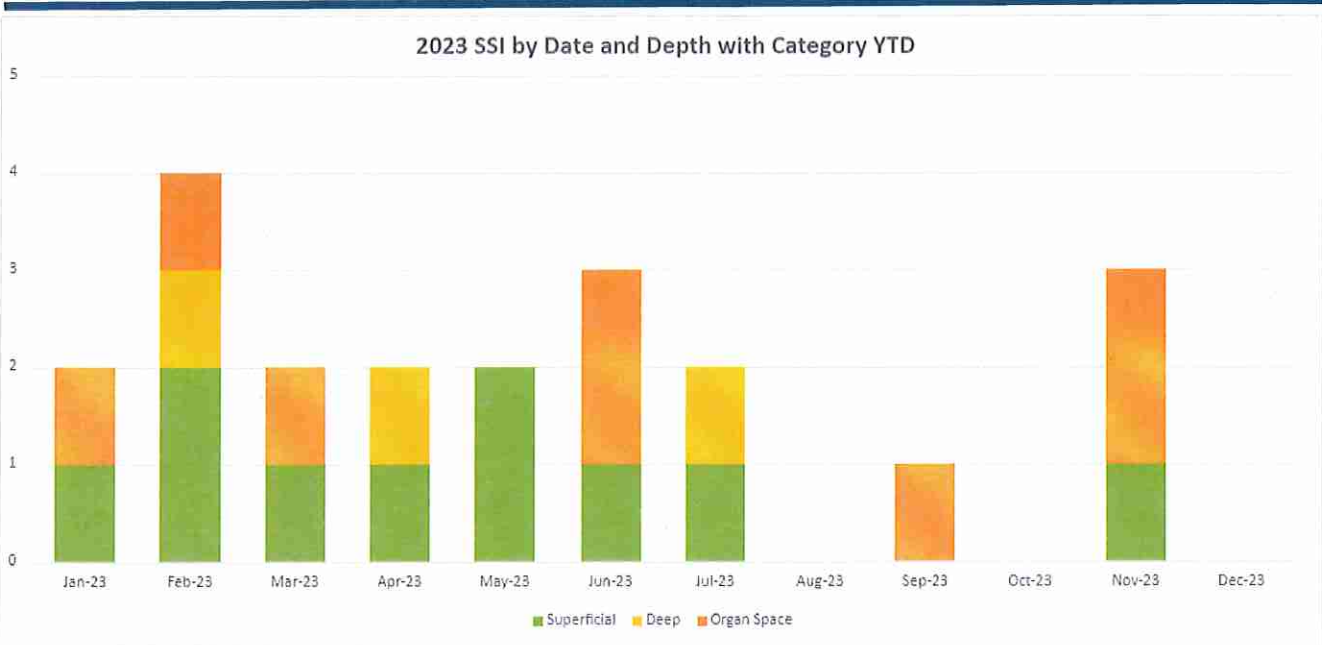
OS -- 8

SIR >1.0: HPRO

Highest SIR: HPRO 2.071



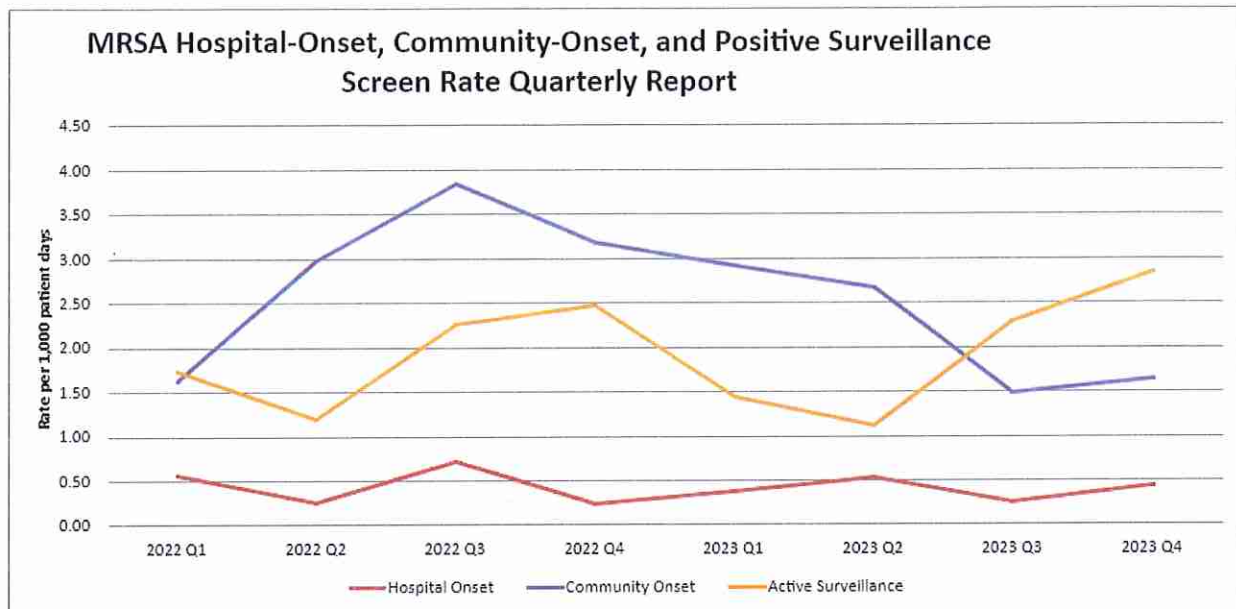
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2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals



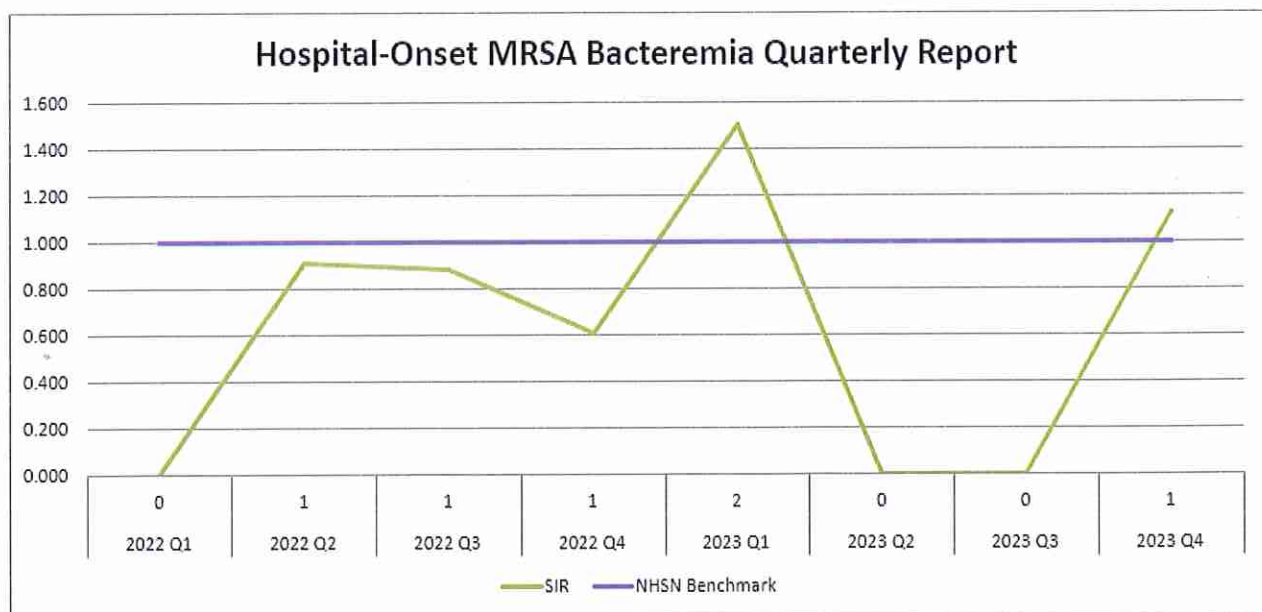
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**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

APPENDIX – D

**Figure 5:** Quarterly MRSA Hospital Onset, Community Onset and Surveillance Screens per 1000 Patients Days

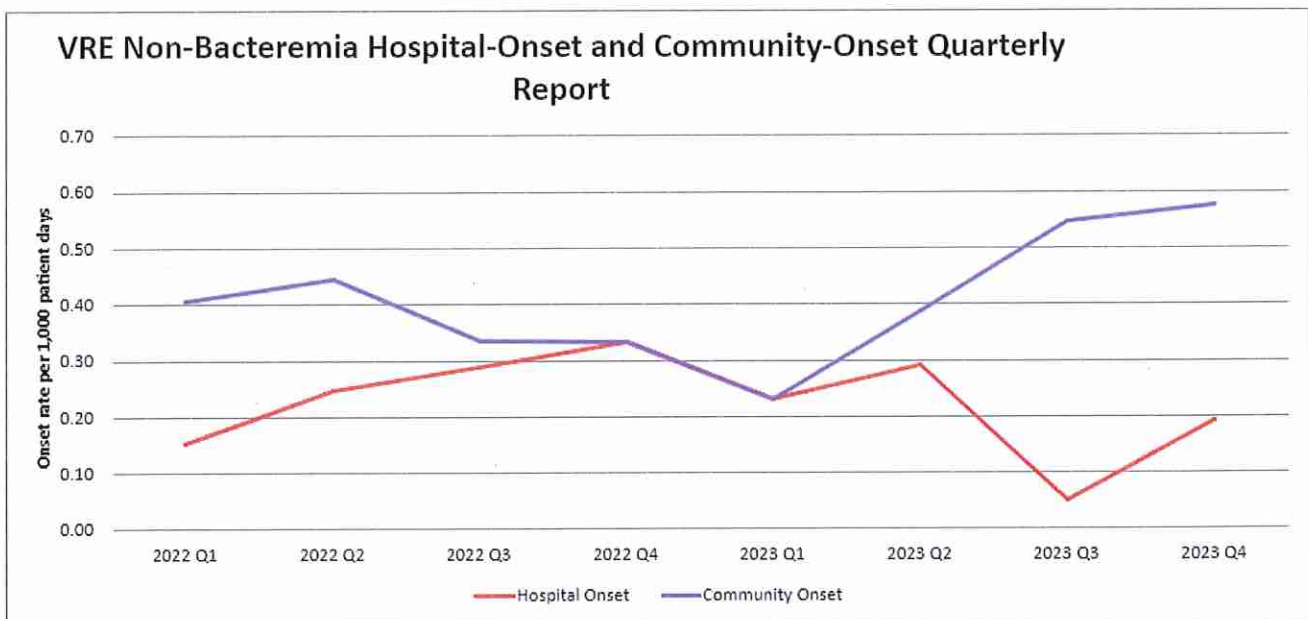
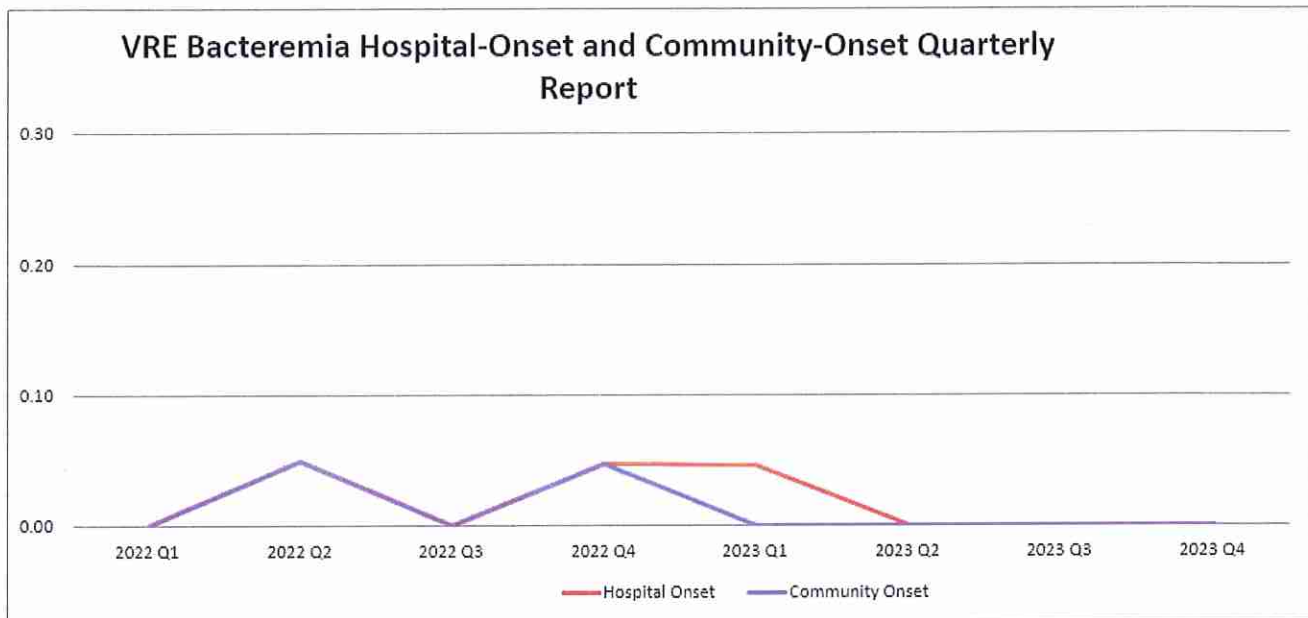


**Figure 6:** Quarterly MRSA Hospital Onset Bacteremia SIR



Providence Little Company of Mary Medical Center Torrance  
2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals

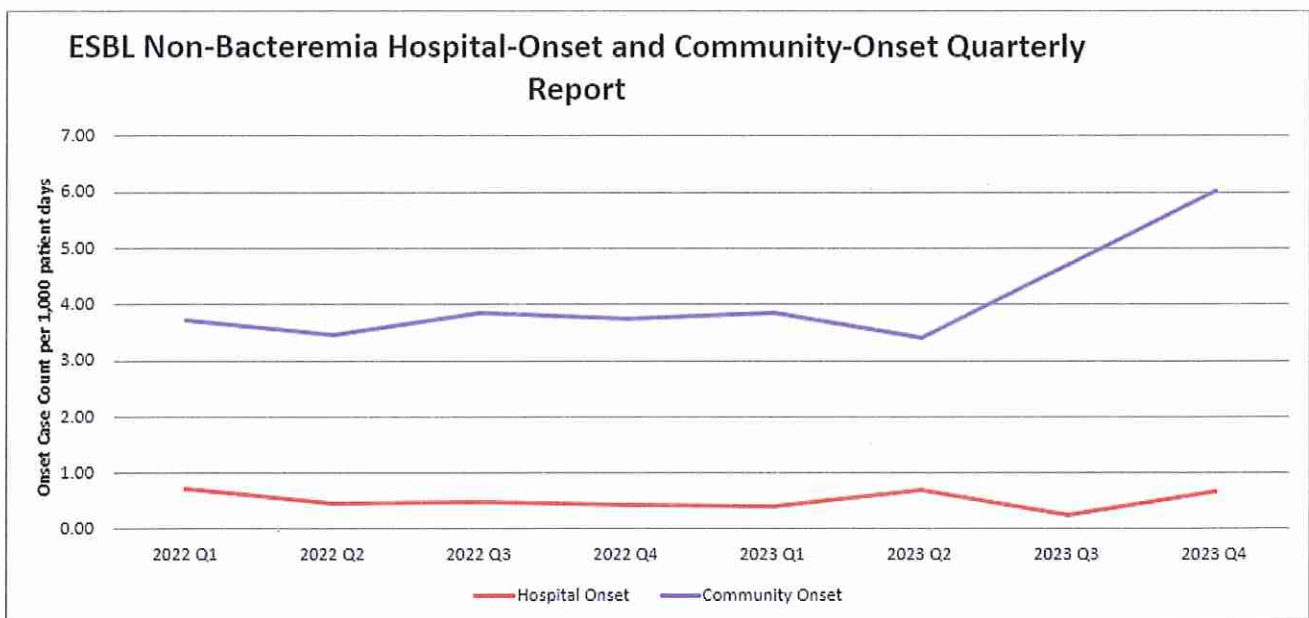
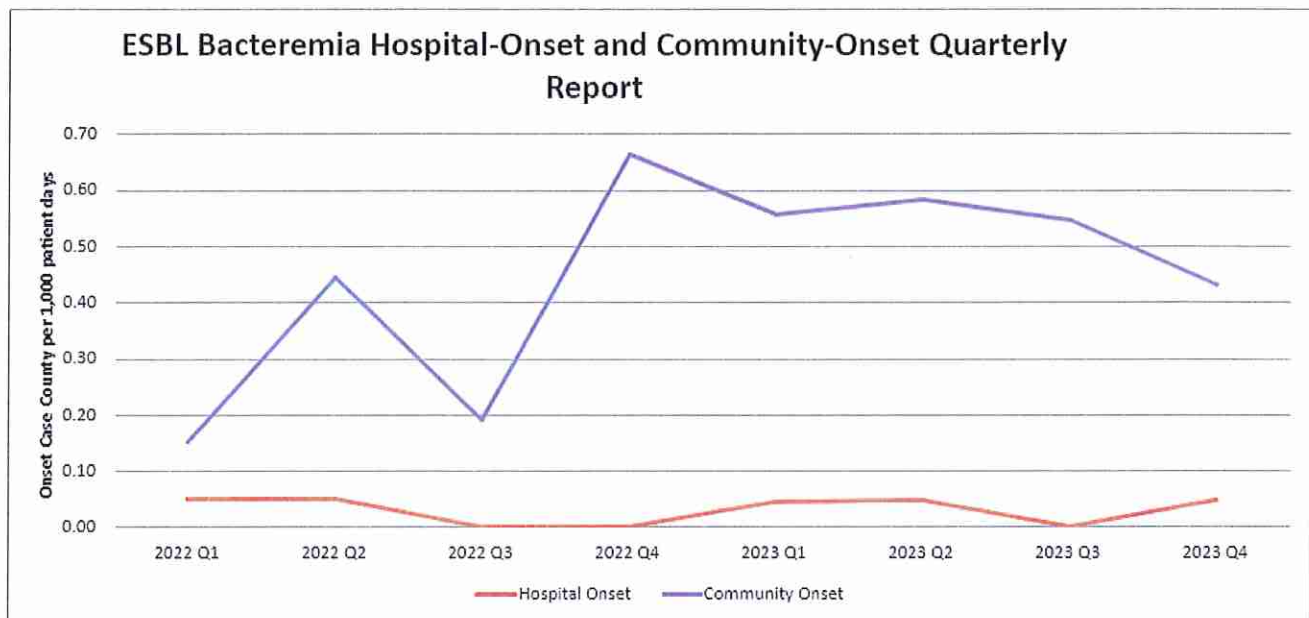
**Figure 7:** Quarterly VRE Hospital Onset, Community Onset and Surveillance Screens per 10,000 Patients Days





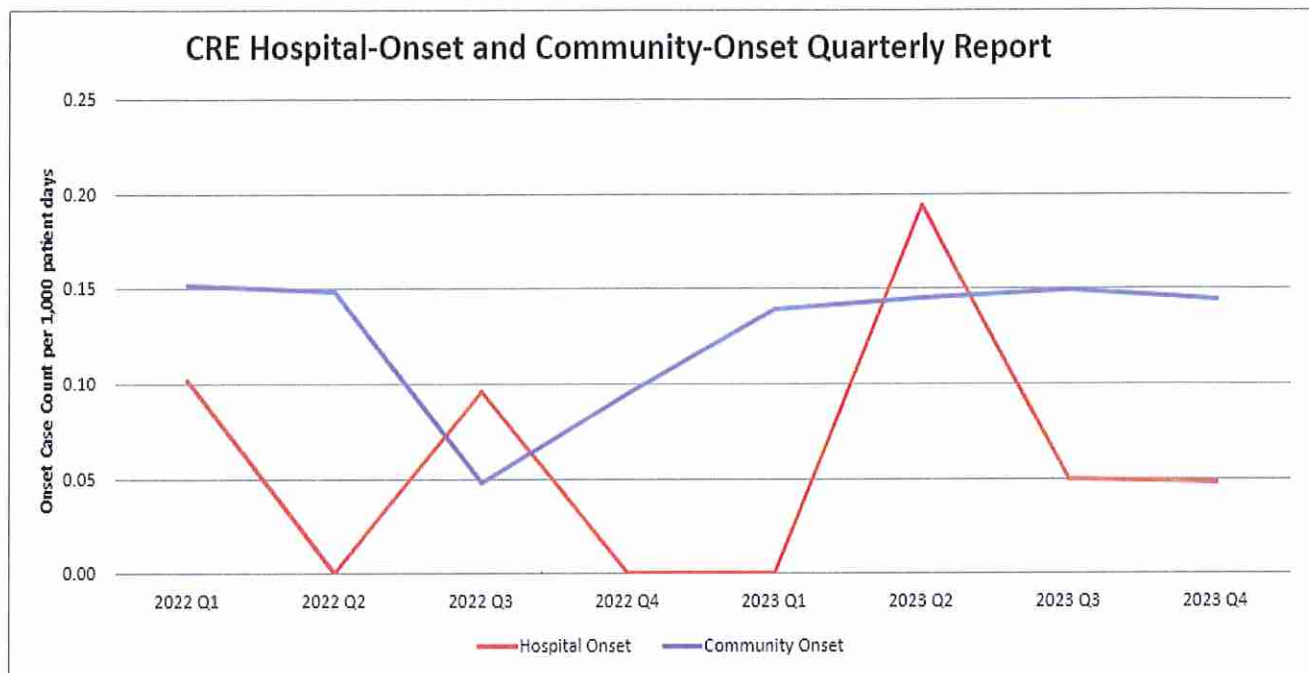
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Figure 8: ESBL Hospital Onset, Community Onset and Surveillance



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2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals

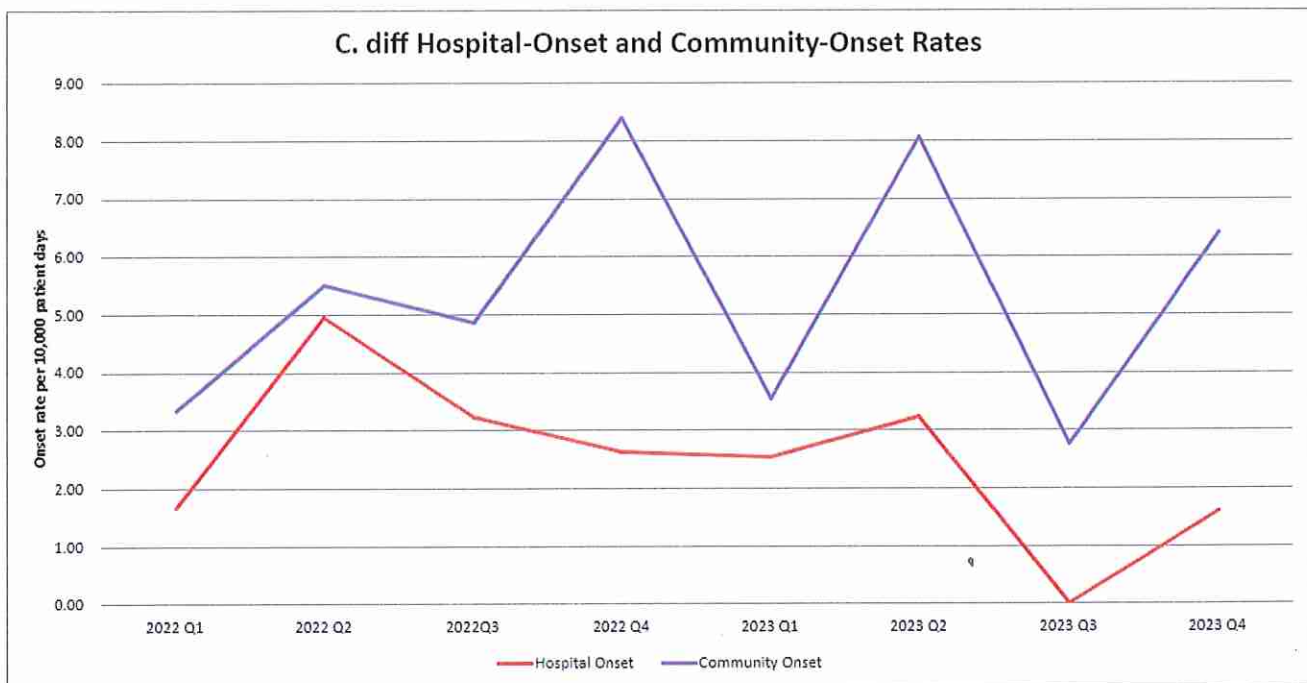
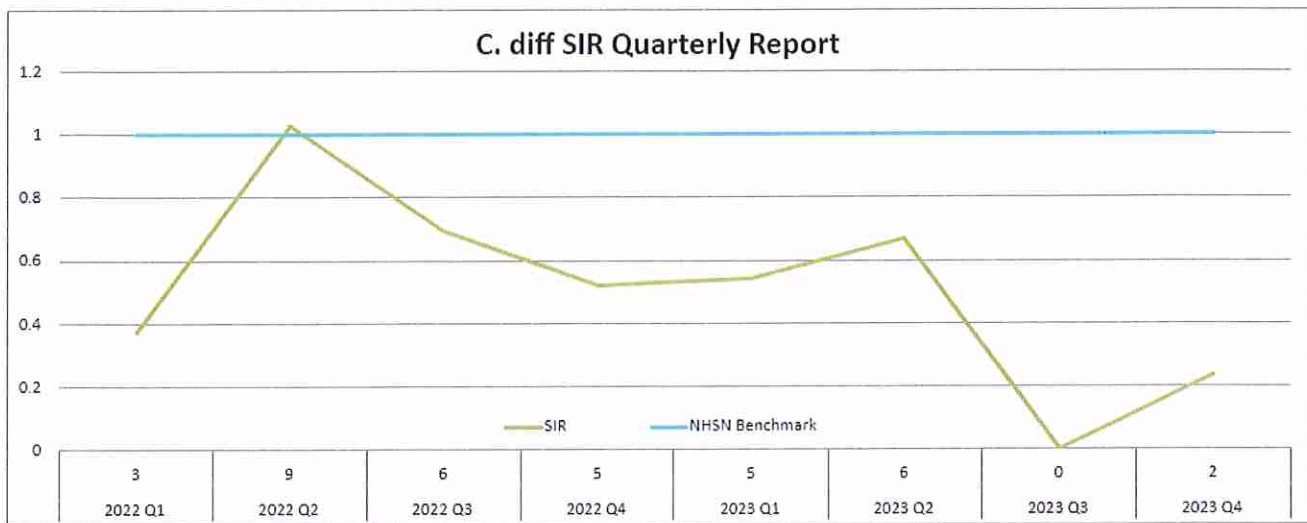
Figure 9: CRE Hospital Onset, Community Onset and Surveillance



There were 12 CO cases and 6 HO cases of CRE identified. All CRE cases are sent to CDPH per guidelines.

**Providence Little Company of Mary Medical Center Torrance**  
**2024 Infection Prevention Annual Risk Assessment, Program Effectiveness and Goals**

**Figure 10: *Clostridioides difficile* Hospital Onset, Community Onset and Surveillance**



\* Community Onset includes patients identified by NHSN as CO-HFA (community onset healthcare facility associated).



Current Status: Pending

PolicyStat ID: 14975247



# Providence

Little Company of Mary  
Medical Center  
Torrance

Origination: 02/2004  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 01/2024  
Next Review: 3 years after approval  
Owner: Munaver Bholat: Senior Director  
Pharmacy  
Policy Area: Medication Management  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Availability of Patient Specific Information for Medication Management

### POLICY:

1. Patient specific information shall be readily available to all licensed ~~independent~~ practitioners (~~LIPs~~) and appropriate health care professionals involved in the medication management of patient's medications which includes prescribing, dispensing, administration, and monitoring processes.
2. At a minimum, the patient's information includes the following:
  - A. Age
  - B. Sex
  - C. Diagnoses, co-morbidities, and concurrently occurring conditions
  - D. Allergies and sensitivities
  - E. Current medications
  - F. Relevant laboratory values
  - G. Weight, height, pregnancy, lactation or any other appropriate information for safe medication management shall be available.
3. Patient specific information shall be available in medical record (EMR).
4. In some emergent situations, all of the patient information may not be available or accessible in the EMR. ~~LIPs~~ Licensed practitioners and health care professionals will assess and obtain information as necessary in emergencies.

### REFERENCE:

Joint Commission Hospital Accreditation Medication Management Standards MM.01.01.01

### Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff Comm - P&T	Mayra Graves: Medical Staff Coordinator	pending
Med Staff Comm - P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
Dir	Munaver Bholat: Senior Director Pharmacy	01/2024
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	01/2024

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

COPY



# Provident

Little Company of Mary  
Medical Center  
Torrance

Origination: 12/2018  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 01/2024  
Next Review: 3 years after approval  
Owner: Munaver Bholat: Senior Director  
Pharmacy  
Policy Area: Medication Management  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Drug Product Vendors' Representatives

### PURPOSE

1. To define the guidelines for representatives of manufacturers and suppliers of drug products, drug-related devices, and other equipment, supplies, and services purchased by pharmacies.
2. To establish the policy to uphold the patient's best interests and ensure that patients' rights of privacy and confidentiality are protected.
3. To establish the policy to ensure that, when necessary, drug vendors' representatives' expertise is available to enhance patient care.

### POLICY STATEMENT

Provident Little Company of Mary Medical Center employees are responsible to maintain the patient's right to privacy and confidentiality.

### DEFINITIONS

1. Vendor representatives (e.g. "sales rep" or "drug rep"): Non-employee of the organization; Agents who promote products and provide information and services to health care providers on behalf of manufacturers and suppliers. Drug vendor representatives serve and interact with settings with respect to drug products, drug-related devices, and other equipment, supplies, and services purchased by pharmacies.
2. Vendor consultant: Non-employee of the organization; a representative of a manufacturer or supplier whose technical expertise has been requested by a physician, nurse, pharmacist, or other professional employee of the medical center.

### PROCEDURE

### POLICY

1. Vendor representatives:
  - a. Vendor representatives will not have access to a patient's protected health information or medical information (i.e. medical record, computer access, or verbal information).



- b. Patient care areas are not appropriate locations for vendor education or sales calls. Vendor representatives are restricted from patient-care areas, pharmacy storage and work areas.
  - c. Vendor representatives are not allowed into the hospital as part of preceptorship.
  - d. Vendor representatives shall register with the Pharmacy Department upon each visit to the hospital and provide the time, purpose, and location of their appointments.
  - e. Vendor representatives conducting legitimate business in patient care areas shall wear a vendor name tag per hospital policy.
  - f. Vendor representatives must leave patient care areas whenever requested by hospital personnel.
2. Vendor consultants:
- ~~1. Vendor consultants must have prior approval from the Pharmacy Director or Pharmacy Manager.~~
  - ~~2. Care providers will have access to a vendor consultant's specialized knowledge of drug products and drug-related devices.~~
  - ~~3. Vendor consultants are allowed in patient care areas only when invited/requested by a physician, nurse, pharmacist, or other professional employee and only with the prior approval of the Pharmacy Director or Pharmacy Manager.~~
  - ~~4. Vendor consultants will not have access to a patient's protected health information or medical information (i.e. medical record, computer access, or verbal information).~~
  - ~~5. The physician of record or the physician's agent (nurse, or others) acting at the direction of the physician, may provide selected medical information to facilitate the acquisition of needed drugs.~~
    - ~~i. The release of such information will abide by the applicable laws and system policies. Authorization will be obtained from the patient or patient's agents as required.~~
  - ~~6. Vendor consultants conducting legitimate business in patient care areas shall wear a vendor name tag per hospital policy.~~
  - ~~7. Vendor consultants must leave patient care areas whenever requested by hospital personnel.~~
  - a. Vendor consultants must have prior approval from the Pharmacy Director or Pharmacy Manager.
  - b. Care providers will have access to a vendor consultant's specialized knowledge of drug products and drug-related devices.
  - c. Vendor consultants are allowed in patient care areas only when invited/requested by a physician, nurse, pharmacist, or other professional employee and only with the prior approval of the Pharmacy Director or Pharmacy Manager.
  - d. Vendor consultants will not have access to a patient's protected health information or medical information (i.e. medical record, computer access, or verbal information).
  - e. The physician of record or the physician's agent (nurse, or others) acting at the direction of the physician, may provide selected medical information to facilitate the acquisition of needed drugs.
    - i. The release of such information will abide by the applicable laws and system policies. Authorization will be obtained from the patient or patient's agents as required.
  - f. Vendor consultants conducting legitimate business in patient care areas shall wear a vendor name

tag per hospital policy.

- g. Vendor consultants must leave patient care areas whenever requested by hospital personnel.
- 3. Interactions between any hospital personnel and vendor representatives/consultants shall comply with the system policies regarding vendor interactions and conflicts of interest.
- 4. Vendor representatives and consultants will be asked to make scheduled appointments in order to meet with appropriate pharmacy department staff and describe the purpose of the visit. Appropriate reasons for engagement with vendor representatives and consultants may include:
  - a. Providing information useful for product evaluation including scientific literature, drug-product safety and efficacy, and documentation of cost benefits.
  - b. Providing timely information on the vendor's products and services.
  - c. Facilitating procurement and crediting transactions.
  - d. Obtaining and providing information necessary to support the hospital's formulary system.
  - e. Facilitating informational activities for the pharmacy staff and other health care professionals with respect to the vendor's products.

## **PROCEDURES**

- 1. The Pharmacy Department will maintain current vendor contact information on file. This information may be provided to professional staff upon request.
- 2. Vendor representatives/consultants conducting legitimate business in the hospital including non-patient care areas, patient care areas, and the pharmacy department must comply with the following procedures:
  - a. Wear a vendor name tag per hospital policy.
  - b. Shall not enter any restricted access areas without prior approval or directly accompanied by authorized hospital personnel. Must leave patient care areas and other restricted access areas of the hospital when requested by hospital personnel.
- 3. Dissemination of informational materials promoting products by vendors' representatives, should be notified to the pharmacy department. Vendors' representatives should provide the pharmacy department with copies of these materials and information about who are the intended recipients of the information (e.g., physicians, specialists, nurses).
  - a. Informational materials may only be disseminated to appropriate recipients with the hospital.
  - b. Promotional materials must adhere to the regulatory standards.
  - c. Drug samples are not allowed to be distributed in the hospital.
- 4. Vendors shall not, without formal written consent, use the organization's or personnel's names in any promotional materials or activities.
- 5. Vendor shall honor formulary decisions made by the Pharmacy and Therapeutics Committee.
- 6. Noncompliance with the policies and procedures by vendors' representatives/consultants shall result in progressive action to include the following:
  - a. Notification to the vendor representative of failure to comply with the policy.
  - b. Notification to the vendor representative's manager or director of noncompliance with the policy.
  - c. The vendor shall be restricted for at least six months from promoting any product in the hospital(s).



All such restrictions shall be notified to the Pharmacy and Therapeutics Committee and any further terms of restriction discussed and approved by the Pharmacy and Therapeutics Committee.

7. Refer to Providence Systemwide policies for additional guidance.

## REFERENCES

1. Providence Systemwide Policy: Vendor/Supplier Interactions
2. Providence Systemwide Policy: Health Care Industry Representatives (HCIR) in Patient Care Areas
3. CA-PH&S Little Company fo Mary Service Area Policy: Security Management Plan
4. American Society of Hospital Pharmacists. ASHP Guidelines for Pharmacists on the Activities of Vendors' Representatives in Organized Health Care Systems. *Am J Hosp Pharm.* 1994; 51:520-1. (Reviewed in 1998 by ASHP Council on Professional Affairs and the ASHP Board of Directors and was found to still be appropriate)
5. American Society of Hospital Pharmacists. ASHP Guidelines on Pharmacists' Relationships with Industry. *Am J Hosp Pharm.* 1992; 49:154. (Reviewed in 2001 by the Council on Legal and Public Affairs and the ASHP Board of Directors and was found to still be appropriate)
6. American Society of Hospital Pharmacists. ASHP Guidelines for Selecting Pharmaceutical Manufacturers and Suppliers. *Am J Hos Pharm.* 1991; 48:523-4.
7. American Society of Hospital Pharmacists. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. *Am J Health-Syst Pharm.* ~~2008~~2021; ~~65~~78;~~4272-83~~ 907-918.

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff Comm - P&T	Mayra Graves: Medical Staff Coordinator	pending
Med Staff Comm - P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
Dir	Munaver Bholat: Senior Director Pharmacy	01/2024
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	01/2024

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance



Current Status: Pending

PolicyStat ID: 14975246



# Providence

Little Company of Mary  
Medical Center  
Torrance

Origination: 03/2018  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 04/2021  
Next Review: 3 years after approval  
Owner: Munaver Bholat: Senior Director  
Pharmacy  
Policy Area: Medication Management  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Herbal Remedies

### POLICY

It is the policy of Providence Little Company of Mary Medical Center that all drugs and medications administered to patients shall be those that are listed in the latest edition of the United States Pharmacopeia – National Formulary (USP-NF).

Therefore herbal supplements are not approved to be administered to patients. To communicate this to all involved providers including physicians and nurses, pharmacy will enter an order to discontinue the medication.

Exceptions to the USP-NF listing requirement must be approved by the Pharmacy and Therapeutics Committee and include:

- N-acetylcysteine oral tablets/capsules
- Fish oil (omega-3 fatty acid)
- Lactobacillus
- Melatonin
- Saccharomyces
- Co-enzyme Q10

For investigational medications see policy: Investigational Drug Use. Institutional Review Board approval must be obtained.

### REFERENCE

*Medical Staff Rules and Regulations*

### Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff Comm - P&T	Mayra Graves: Medical Staff Coordinator	pending
Med Staff Comm - P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	01/2024
Dir	Munaver Bholat: Senior Director Pharmacy	01/2024

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

COPY



# Providence

## Little Company of Mary Medical Center Torrance

Origination: 02/2019  
Effective: 02/2019  
Last Approved: N/A  
Last Revised: N/A  
Next Review: 3 years after approval  
Owner: Munaver Bholat: Senior Director  
Pharmacy  
Policy Area: Medication Management  
References:  
Applicability: CA - PH&S Little Company of  
Mary Service Area

## Parenteral Nutrition

### PURPOSE:

To provide physicians, pharmacists, and dietitians with a guideline to the ordering, administration, and management of parenteral nutrition (PN) solutions at Providence Little Company of Mary Medical Centers South Bay community. This policy also allows pharmacists and dietitians to manage PN upon prescribing physician's request.

### POLICY:

#### A. Ordering and Administration of Parenteral Nutrition (PN):

1. PN will be ordered using Adult or Pediatric Nutrition orders in the EPIC system.
2. New orders and changes must be received by 1500 daily.
3. All TPNs will have an standard administration time of 2100
4. All TPN bags will be changed and a new bag shall be hung at 2100.
5. Once the PN bag is hung, no additions can be made to the bag.
6. PN must be infused via an IV infusion device.
7. All IV administration sets used for PN will be changed with every new bag.
8. PN via peripheral IV access (including midlines) will have a maximum osmolarity of ~~1400~~900 mOsm/Liter. Formulations exceeding this concentration will require administration through a central venous catheter.
9. PN with dextrose concentrations greater than D10% for adults or D12.5% for pediatric and neonatal patients require administration through a central venous catheter.

#### B. Management of Parenteral Nutrition:

1. Pharmacists monitor all patients receiving Parenteral Nutrition (PN). This includes:
  - a. Screening of initial orders for appropriate, caloric, nutrient, and electrolyte needs of patients.
  - b. Routine monitoring and evaluating changes in PN needs for patients.



- c. Monitoring and evaluating pertinent laboratory values (i.e. BUN, SCr, LFTs, electrolytes, etc.) daily by the pharmacist and at least weekly by the dietitian.
- d. If PN is not available or if there is an interruption in PN infusion, initiate D10W infusion at the current rate and notify the physician.
- e. Pharmacists managing Parenteral Nutrition will need to complete competency training.

## C. Parenteral Nutrition per pharmacy services

1. Physicians may choose to request the Department of Pharmacy along with Clinical nutrition services to initiate or adjust PN therapy for patients. If no consult is requested, pharmacists and dietitians will monitor all patients on PN and discuss any recommendation for changes with the physician.
2. By requesting "Parenteral Nutrition per Pharmacy", physicians will give the pharmacist authority to initiate/ make adjustments to the following:
  - a. PN formulation:
    - i. Pharmacists will initiate and/or make changes to the PN formulation and additives based on the dietitian's recommendations as clinically indicated. If no recommendations are available, pharmacists should contact the clinical dietitian to request that information. Initial rate of new PN orders should be clarified with a clinical dietitian to prevent re-feeding syndrome.
    - ii. Lipids
      - a. Lipids are ordered as the 20% concentration for adults and pediatrics.
      - b. The infusion time for a unit of lipid solution will not exceed 24 hours after spiking the container (12 hour infusion is preferred).
      - c. Lipids may be ordered once daily or less frequently based on patient's needs. Initial dosing should be less frequent (i.e. Mondays, Wednesdays, Fridays) and then increase to daily.
      - d. Triglyceride (TG) levels (see also "Laboratory tests")
        1. In order to obtain accurate triglyceride levels, blood samples should be drawn at least six hours after the lipid infusion is completed.
        2. Pharmacists may adjust lipids for abnormal triglyceride levels.
        3. Elevated TG levels will be discussed with the physician.
        4. If patient is started on propofol continuous infusion, the pharmacist will discontinue lipids from therapy (unless otherwise specified by the physician). When propofol is discontinued, lipids may be resumed.
    - iii. Electrolytes:
      - a. Pharmacists will make appropriate changes of PN electrolyte content based on daily laboratory values.
      - b. Pharmacists will review laboratory data daily and compare it to the accepted standard reference ranges adjusted for age as reported in EPIC. The trend in laboratory data will also be evaluated prior to making changes in PN content. Deviation from the standard reference range adjusted for age may be necessary based on an individual patient's needs.
      - c. Pharmacists will evaluate the clinical status of the patient (i.e. renal and hepatic function, concurrent medications, etc) prior to making changes/initiating PN.

b. Laboratory tests:

- i. Pharmacists may order appropriate baseline and maintenance laboratory tests. Within 24 hours of initiating PN, a baseline laboratory profile is obtained (i.e. comprehensive metabolic panel, CBC, magnesium, phosphorus, triglyceride level)
  - a. Initially, comprehensive metabolic panel (CMP) is ordered daily for the first 3 days of PN therapy. Thereafter, CMP every other day and a CBC and PT ordered once weekly with additional laboratory tests ordered as necessary by the pharmacist.
  - b. Triglyceride level is repeated 24-48 hours after the initial lipid infusion to check for lipid clearance. Monitor triglyceride level on a weekly basis for the duration of therapy.

c. Glycemic control:

- i. Pharmacists are authorized to initiate or adjust insulin therapy and glucose monitoring for proactive glucose management in patients on PN.
- ii. If a patient is not already on insulin therapy, pharmacists are authorized to initiate low-dose regular insulin correction scale and point of care glucose testing at least four times daily (Q6H, or AC&HS if eating)
- iii. Further adjustments shall be discussed with provider or in appropriate patients pharmacists will utilize the **Glycemic Control Protocol**.

3. Documentation:

- a. Pharmacist will generate progress notes regarding changes in PN formulation.
- b. Further communications will be provided by the pharmacists to the health care team as indicated.

## References:

Providence Systemwide policy: Total Parenteral Nutrition (TPN) Policy

Providence LCM MC Torrance and LCM MC San Pedro policies: Clinical Dietetics: Total Parenteral Nutrition

ASHP Nutrition Support Resources

**ASPEN Guidelines**

Boullata J, Gilber K, Sacks G, et al. A.S.P.E.N. Clinical Guidelines: Parenteral Nutrition Ordering, Order Review, Compounding, Labeling, and Dispensing. *J Parenteral and Enteral Nutrition*. 2014;38:334-77.

Nickel, B, et al. Infusion ~~Nurses Society~~ Therapy Standards of Practice, ~~Infusion Therapy Standards of Practice~~ 9th edition. *J Infusion Nursing*. 2024;47(1S Suppl1), pp.S1-S285.

The Joint Commission, Comprehensive Manual for Accreditation of Acute Care Hospitals, Medication Management Standards

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff Comm - P&T	Mayra Graves: Medical Staff Coordinator	pending
Med Staff Comm - P&T	Mary Guglielmo: Associate Continuing Medical Education Coordinator	pending
Dir	Munaver Bholat: Senior Director Pharmacy	01/2024
Dir	Pamela Almeida: Principal Safety Officer Pharmacy	01/2024

## Applicability

CA - Providence LCM MC San Pedro, CA - Providence LCM MC Torrance

COPY





# Providence

Little Company of Mary  
Medical Center  
Torrance

Origination: 08/2017  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 02/2024  
Next Review: 3 years after approval  
Owner: Navnidhee Batra: Manager  
Clinical Dietetics  
Policy Area: Food and Nutrition  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## Clinical Dietetics: Nutrition Screening

### POLICY:

It is the policy of Providence Little Company of Mary Medical Center Torrance to define a systematic and interdisciplinary process to screen all hospitalized patients within 24 hours of admission for nutritional risk and to provide appropriate nutritional care in a timely, effective and efficient manner.

### PROCEDURE:

- Nutritional screening is conducted on all patients within 24 hours of admission to determine the need for further comprehensive nutritional assessment as appropriate.
- Patients are screened using a collaborative process with the Nursing Department. The registered nurse completes a validated nutrition screening tool (NRS2002) in the electronic medical record as patients are admitted. The level of nutrition risk (high, moderate, or low) is determined by the score from the validated tool in conjunction with global screening criteria listed in the grid below. This step is completed by the registered dietitian and or nutrition assistant.
- Nutrition Screening Criteria:**

High Risk	Moderate Risk	Low Risk
<b>Nutrition Screening Total Score <math>\geq 3</math> (see reference for screening tool)</b> Tube Feeding Parenteral Nutrition Large or non-healing wound, burn or Stage 3 or 4 pressure injury, Unstageable Pressure Injury and Suspected Deep Tissue Injury (as listed on wound report) Admitting Diagnosis: <ul style="list-style-type: none"> <li>Malnutrition</li> <li>Failure to Thrive</li> <li>Short Bowel</li> </ul>	18+ year old BMI $\leq 18.5$ Stage 1, Stage 2 Pressure Injuries, Diabetic Ulcers (as listed on wound report) Multiple food allergies (see #8) Dysphagia or thicken liquid diet order <u>(when ordered by Speech Language Pathologist)</u> Admitting Diagnosis: <ul style="list-style-type: none"> <li>Bariatric</li> <li>Lower GI Cancer (small intestine, colon)</li> <li>Bariatric</li> </ul>	<b>Nutrition Screening Total Score 0-2 (see reference for screening tool)</b> <u><math>&gt; 7</math> day LOS (on day 8)</u>

<p><b>New-onset diabetes mellitus</b></p> <ul style="list-style-type: none"> <li>◦ On Vent</li> <li>◦ Traumatic Brain Injury</li> <li>◦ Pregnancy with risk factors: <ul style="list-style-type: none"> <li>▪ <b>Diabetes: Type 1, Type 2</b></li> <li>▪ <b>Gestational Diabetes (antepartum)</b></li> <li>▪ <b>Pregnancy-Induced Hypertension (not in active labor)</b></li> <li>▪ <b>Hyperemesis (antepartum)</b></li> <li>▪ <u>Hyperemesis (antepartum)</u></li> </ul> </li> <li>◦ <b>Upper</b>-GI Cancer (Tongue, Mouth, Throat, Esophageal, Stomach, <u>Liver, Pancreas</u>)</li> </ul>	<ul style="list-style-type: none"> <li>◦ <u>GI Cancer (small intestine, colon, Gall Bladder, Biliary tract)</u></li> <li>◦ <u>New onset diabetes mellitus</u></li> <li>◦ <u>Pregnancy with risk factors: Diabetes- Type 1, Type 2, Gestational Diabetes (antepartum); Pregnancy Induced Hypertension (not in active labor)</u></li> </ul> <p>If 2 or more factors are identified, the patient will be placed at high risk</p>	
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- High risk patients will be nutritionally assessed within 24-48 hours of admission.
- Moderate risk patients will be nutritionally assessed within 48-72 hours of admission.
- Low risk patients will receive basic nutritional services that include the following:
  - 3 meals per day
  - selected menu
  - snacks as requested or ordered
  - menu checked for accuracy according to diet order
  - interaction with the diet assistant
  - > 7 day LOS (on day 8) Nutrition Assessment
- NPO/Clear Liquid Diet > 4 days will be screened on Day 5, comprehensive assessment may not be needed. Re screen in 2 days - if diet not advancing, comprehensive assessment will be completed. Only for patients on ICU that are NPO/Clear Liquid > 3 days, comprehensive assessment will be completed on Day 4.
- Multiple food allergies is defined as patients with allergies to **23** or more of the top **89** food allergens (eggs, milk, shellfish, fish, peanuts, tree nuts, soybeans, sesame and wheat), ~~or 3 or more food allergies, if they only have one of the top 8 allergens.~~
- Post Partum patients less than 18 years old, who plan to breastfeed, will receive a nutrition plan for breastfeeding prior to discharge by a Registered Dietitian or a trained designee.
- Consults will be assessed within following time frames:
  - Consult for new TPN or Tube feeding (within 24 hours)
  - MD/RN consult for any other reason (within 24-48 hours)
- Using the priority system, the dietitians will complete nutritional assessments as appropriate and a nutritional plan of care will be implemented within the established time frames.

## REFERENCE(S) / RELATED POLICIES:

- ESPEN Guidelines for Nutrition Screening 2002 J. KONDRUP, S. P. ALLISON, M. ELIA, B.VELLAS,M. PLAUTH. Clinical Nutrition (2003) 22(4): 415–421
- Document Central policy number: LCT-CD-203

<b>Board Approved:</b>	6/98, 6/10, 11/11, 11/14
<b>Reviewed:</b>	6/00, 10/05, 10/11, 3/13, 6/14, 3/16
<b>Revised:</b>	6/98, 5/03, 10/06, 6/09, 7/09, 5/10, 6/11, 11/12, 4/14,12/15, 3/16, 10/16, 3/17, 6/20, 1/22, <u>2/24</u>

*This policy was developed in collaboration with the following involved departments:*

Nursing, Clinical Informatics and the Regional Clinical Nutrition Managers

## Attachments

No Attachments

## Approval Signatures

Step Description	Approver	Date
Med Staff - P&T	Mayra Graves: Medical Staff Coordinator	pending
Policy Committee	Patti Hamaguchi: Executive Director Quality	02/2024
Policy Committee	Navnidhee Batra: Manager Clinical Dietetics	02/2024

## Applicability

CA - Providence LCM MC Torrance



Current Status: *Pending*

PolicyStat ID: 15013627



# Provident

Little Company of Mary  
Medical Center  
Torrance

Origination: 04/2021  
Effective: Upon Approval  
Last Approved: N/A  
Last Revised: 04/2021  
Next Review: 3 years after approval  
Owner: Edgar Flemate: Director Facilities  
Policy Area: Facilities  
References:  
Applicability: CA - Providence LCM MC  
Torrance

## POM: Medication Refrigerator Temperature Monitoring

### POLICY:

The purpose of this procedure is to provide a method of monitoring medication refrigerators and taking corrective action based on temperature readings that are "out of range".

### PROCEDURE:

All medication refrigerators at LCMH are connected to the Energy Management System (EMS). Sensors are located in every medication refrigerator; these transmit the temperature reading to the EMS main computer located in the Central Plant. These temperatures are displayed on a separate screen that shows all refrigerator locations by name, the current temperature readings of each refrigerator, minimum and maximum temperature set points, and an alarm box for each refrigerator.

The temperature for these refrigerators shall be maintained between 36 and 46 degrees Fahrenheit. If the temperature falls out range, either high or low, it will display an alarm on the monitor. If the temperature does not correct itself within 60 minutes the EMS system will automatically page the shift engineer on his alpha pager alerting him of the alarm. The shift engineer is a 24 hour seven-day-a-week position. The shift engineer will then check the EMS system display screen to find out what refrigerator is in alarm. He will then respond to take corrective action. This corrective action is documented in the Medication Refrigerator Log Book located in the POM department.

The EMS system will take a sampling of all temperatures once every 24 hours. This report is automatically generated and placed in the Medication Refrigerator Log File for future reference to comply with CCR, Title 22 regulations and other applicable standards. These reports are available from the Plant Operations and Maintenance department. Records will be stored for a period of one year on the EMS computer and for three (3) years in the log file.

### DOCUMENTATION:

1. Medication Refrigerator Corrective Action Form
2. Medication Refrigerator Sampling Report
3. Medication Refrigerator Corrective Action Log Book

## REFERENCE:

- Document Central Policy Number: LCT-POM-050

## Attachments

[Medication Refrigerator Alarm Response Log Form](#)

## Approval Signatures

Step Description	Approver	Date
Med Staff - P&T	Mayra Graves: Medical Staff Coordinator	pending
Policy Committee	Patti Hamaguchi: Executive Director Quality	01/2024
Policy Committee	Edgar Flemate: Director Facilities	01/2024

## Applicability

CA - Providence LCM MC Torrance

## Medication Refrigerator Alarm Response Log

Refrigerator Name/Number

[illegible]



# Privileges in Obstetrics and Gynecology (cont.)

Name: \_\_\_\_\_

Requested	Procedure	Approved	Number of cases needed every 24 months to obtain/retain privilege. *	Additional Criteria (when applicable)	Number of cases to be proctored.
	<p>DaVinci Surgical Platform (MEC approved October 2013)</p> <p><i>*Documentation requirements via (case logs) with demonstrated performance of a minimum of twenty (20) robotic-assisted console cases in previous 24 months</i></p> <p>Please indicate which DaVinci Surgical Platform and System to support your privileges request:</p> <p><input type="checkbox"/> Si Da Vinci</p> <p><input type="checkbox"/> Xi Da Vinci</p>		<p>*20 See "document" requirements</p>	<p><u>FELLOWSHIP/RESIDENT TRAINED ROBOTICS &amp; FROM OTHER ROBOTICS PROGRAMS:</u></p> <p>Board certification <u>or eligibility</u>, Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence.</p> <p>AND</p> <p>Documented competency to independently perform robotic surgery successfully from completion of residency/fellowship training in Robotic-Assisted Surgery that includes a minimum 20 robotic console cases</p> <p>OR</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p><u>NEW to ROBOTICS:</u></p> <p>Board certification, Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p>Proctoring must be completed within 12 months, or applicant must re-apply with <i>new</i> certificate for privilege</p> <p><b>IN ADDITION, must meet the Si and/or Xi criteria by 1) submission of Da Vinci certificate of completion of on-line modules for Si and/or Xi criteria and 2) signed completion of hands-on training with Surgical Intuitive representative for the applicable Da Vinci Si and/or Xi platform and system.</b></p>	4

## Providence Little Company of Mary Medical Center Torrance Otolaryngology Privileges

Name: \_\_\_\_\_

### Otolaryngology core privileges

#### Qualifications

To be eligible for core privileges in otolaryngology, the applicant must meet the following qualifications:

- Documentation of the performance of at least 24 Otolaryngology surgical procedures **in the areas of head and neck, plastic, reconstructive, and otologic surgery** in the past 24 months, in a Medicare approved outpatient surgicenter or an acute care hospital, or demonstrated successful completion of a hospital-affiliated residency or clinical fellowship, in the past 24 months;

AND

- Surgeons who are Certified by the American Board of Otolaryngology

OR

- Surgeons who have completed training equivalent to that required for Certification by the American Board of Otolaryngology.

### Privileges included in the core

- Must be proctored for the first five [5] major cases of a varying nature
- Any item included in the core that you do not wish to request, or be granted, please line through.
- Privileges to admit, perform history and physical, evaluate, diagnose, and provide nonsurgical care in Acute Care and TCC/TCU. Provide surgical care to patients above the age of 10, to correct or treat illnesses, injuries, and disorders of the head and neck affecting the ears, nose, facial skeleton, and respiratory and upper alimentary systems in the Acute Care setting only.

The core privileges in this specialty include the procedures in the attached list and such other procedures that are extensions of the same techniques and skills.

<input type="checkbox"/> Requested	<input type="checkbox"/> Approved	Appointment/Reappointment requires documentation of a minimum of 24 otolaryngology surgeries, in a Medicare approved outpatient surgicenter, IMQ accredited outpatient surgicenter, or an *acute care hospital, within the past 24 months. *At least 25 <b>20</b> % of the cases must be from an acute care hospital.
<input type="checkbox"/> Requested	<input type="checkbox"/> Approved	Assistant Only (Does Not Include Otolaryngology Core Privileges)
<input type="checkbox"/> Deferred because of the following reason(s):		

**Proctoring Reciprocity:** 2/5 from another hospital as long as the proctor is a member in good standing of the Active or Courtesy Medical Staff at PLCMMCT and is not associated with the Provisional member being proctored.

## Otolaryngology Privileges (cont.)

Name: \_\_\_\_\_

**Proctoring Duration:** Proctoring must be completed within twelve months of approval of privilege/s.

### Special procedures privileges

To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the medical staff policies governing the exercise of specific privileges

Requested	Procedure	Approved	Number of cases needed every 24 months to obtain/retain privilege. *	Additional Criteria (when applicable)	Number of cases to be proctored.
	Pediatric Surgery (<10 years of age)		4		1
	*Inspire Hypoglossal Nerve Stimulator Implant		2 <u>3</u>	Evidence of successful training to perform this procedure.	1
	Rathke's Cleft Cyst Endonasal Surgery Anterior Skull-Base Surgery		3	Evidence of successful training to perform this procedure.	1
	Microvascular Flap and Transfer and/or Placement		2 <u>3</u>	Evidence of successful training to perform this procedure.	1
	Operative Neurotology (posterior and middle fossa craniotomy)		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Stereotactic Radiosurgery		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Surgery of the Pituitary Gland		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Robotic Surgery of the Oral Cavity and Pharynx		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Central Venous Catheter Insertion		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Ultrasound of the Head and Neck		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>
	Cochlear Implantation		<u>3</u>	Evidence of successful training to perform this procedure.	<u>1</u>



## Otolaryngology Privileges (cont.)

Name: \_\_\_\_\_

Requested	Procedure	Approved	Number of cases needed every 24 months to obtain/retain privilege. *	Additional Criteria (when applicable)	Number of cases to be proctored.
	Cleft lip/palate repair		3	Evidence of successful training to perform this procedure.	1
	Sialadenoscopy with/without removal of stones		3	Evidence of successful training to perform this procedure.	1

\* For reappointment, the number of these cases performed at PLCMMCT within the past 24 months will be obtained for you by the Medical Staff Services personnel. If you have not completed an adequate number of cases here, you must submit a facility generated patient activity/procedure case list from an acute-care hospital or Medicare approved outpatient surgicenter to substantiate your request/s.

Note: If you cannot document the required number of cases (completed within the past 24 months) for each privilege you have requested, you shall be deemed to have voluntarily surrendered such privilege/s, and the procedural rights set forth in ARTICLE VII, of the Bylaws, shall not be applicable.

### Acknowledgement of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Providence Little Company of Mary Medical Center Torrance, and

I understand that:

- In exercising any clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
- Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## Otolaryngology Privileges (cont.)

Name: \_\_\_\_\_

### Department Chair or Designee Recommendations

I have reviewed the requested clinical privileges and supportive documentation for the above-named applicant and recommend action on the privileges as noted above.

Department Chair or Designee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Medical Executive Committee Approval: \_\_\_\_\_

Board of Directors Approval: \_\_\_\_\_

## Otolaryngology Privileges (cont.)

Name: \_\_\_\_\_

### Otolaryngology (in Acute Care only) Core Procedure List

(Any item included in the core that you do not wish to request, or be granted, please line through.)

<p>Airway and Hypopharyngeal Endoscopy, includes</p> <ul style="list-style-type: none"> <li>Bronchoscopy</li> <li>Esophagoscopy</li> <li>Laryngoscopy</li> </ul> <p>Head and Neck Surgery, includes</p> <ul style="list-style-type: none"> <li>Branchial Cystectomy</li> <li>Cervical Esophagectomy</li> <li>Cervical Lymphadenectomy</li> <li>Glossectomy</li> <li>I&amp;D of Abscess</li> <li>Laryngectomy</li> <li>Parathyroidectomy</li> <li>Radical Neck Dissection</li> <li>Temporal Artery Biopsy</li> <li>Thyroglossal Cyst Excision</li> <li>Thyroidectomy</li> <li>Tracheostomy</li> <li>Trans-Sphenoid Pituitary Approach</li> </ul> <p>Intraoral Surgery, includes</p> <ul style="list-style-type: none"> <li>Palate and Floor of Mouth</li> <li>Tongue</li> </ul> <p>Salivary Gland Surgery, includes</p> <ul style="list-style-type: none"> <li>Mandibulectomy</li> <li>Submandibular Gland and Parotid Surgery</li> </ul> <p>Otolaryngology Surgery, includes</p> <ul style="list-style-type: none"> <li>Adenoidectomy</li> <li>Decompression of Facial Nerve Includes</li> <li>Endoscopic Sinus Surgery</li> <li>Internal Maxillary Artery Ligation</li> <li>Labyrinthectomy</li> <li>Nasal Polypectomy</li> <li>Power Assisted Functional Endoscopic Surgery</li> <li>Rhinoplasty</li> <li>Septoplasty</li> <li>Sinus Surgery</li> <li>Submucous Resection</li> <li>Tonsillectomy</li> <li>Turbinate Resection</li> <li>Uvulopalatopharyngoplasty</li> </ul>	<p>Otology Otologic Surgery, includes</p> <ul style="list-style-type: none"> <li>Mastoidectomy</li> <li>Myringoplasty</li> <li>Myringoplasty with Tube Incisions Placement</li> <li>Myringotomy</li> <li>Nasolacrimal Surgery</li> <li>Stapedectomy</li> <li>Tympanoplasty</li> </ul> <p>Plastic Surgery, includes</p> <ul style="list-style-type: none"> <li>Blepharoplasty</li> <li>Bone Grafts</li> <li>Chemabrasion</li> <li>Cleft lip/palate repair (moved to special procedures)</li> <li>Dermabrasion</li> <li>Eyelid Lacerations</li> <li>Eyelid Lesions - Malignancies and Lacerations</li> <li>Facial Liposuction</li> <li>Facial Fractures -Mandible</li> <li>Facial Soft Tissue Trauma</li> <li>Full Thickness Skin Grafts</li> <li>Hair Transplants</li> <li>Insertion of Facial Implants</li> <li>Lip Reconstruction</li> <li>Local Flaps</li> <li>Myocutaneous Flaps</li> <li>Pedicle Flaps</li> <li>Partial Thickness Skin Grafts</li> <li>Otoplasty</li> <li>Palate Repair</li> <li>Rhytidectomy</li> <li>Scar Revision</li> <li>Tarsorrhaphy</li> </ul> <p>Lasers, includes</p> <ul style="list-style-type: none"> <li>CO<sub>2</sub></li> <li>KTP</li> <li>Nd: YAG</li> <li>SLT</li> <li>Candella</li> </ul>
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## General Surgery Privileges (cont.)

Name: \_\_\_\_\_

Requested	Procedure	Approved	Additional Criteria (when applicable)	Number of cases to be proctored.
	<p>DaVinci Surgical Platform (MEC approved October 2013)</p> <p><i>*Documentation requirements via (case logs) with demonstrated performance of a minimum of twenty (20) robotic-assisted console cases in previous 24 months</i></p> <p>Please indicate which DaVinci Surgical Platform and System to support your privileges request:</p> <p><input type="checkbox"/> Si Da Vinci</p> <p><input type="checkbox"/> Xi Da Vinci</p>	<p>Number of cases needed every 24 months to obtain/retain privilege. *</p> <p>*20</p> <p>See "document" requirements</p>	<p><u>FELLOWSHIP/RESIDENT TRAINED ROBOTICS &amp; FROM OTHER ROBOTICS PROGRAMS:</u></p> <p>Board certification <u>or</u> eligibility, Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence.</p> <p>AND</p> <p>Documented competency to independently perform robotic surgery successfully from completion of residency/fellowship training in Robotic-Assisted Surgery that includes a minimum 20 robotic console cases</p> <p>OR</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p><u>NEW to ROBOTICS:</u></p> <p>Board certification, Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p>Proctoring must be completed within 12 months, or applicant must re-apply with new certificate for privilege</p> <p><b>IN ADDITION, must meet the Si and/or Xi criteria by 1) submission of Da Vinci certificate of completion of on-line modules for Si and/or Xi criteria and 2) signed completion of hands-on training with Surgical Intuitive representative for the applicable Da Vinci Si and/or Xi platform and system.</b></p>	4

## Urology Privileges (cont.)

Name: \_\_\_\_\_

Requested	Procedure	Approved	Number of cases needed every 24 months to obtain/retain privilege. *	Additional Criteria (when applicable)	Number of cases to be proctored.
	<p>DaVinci Surgical Platform (MEC approved October 2013)</p> <p><i>*Documentation requirements via (case logs) with demonstrated performance of a minimum of twenty (20) robotic-assisted console cases in previous 24 months</i></p> <p>Please indicate which DaVinci Surgical Platform and System to support your privileges request:</p> <p><input type="checkbox"/> Si Da Vinci</p> <p><input type="checkbox"/> Xi Da Vinci</p>		<p>*20</p> <p>See "document" requirements</p>	<p><u>FELLOWSHIP/RESIDENT TRAINED ROBOTICS &amp; FROM OTHER ROBOTICS PROGRAMS:</u></p> <p>Board certification <u>or eligibility</u>. Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence.</p> <p>AND</p> <p>Documented competency to independently perform robotic surgery successfully from completion of residency/fellowship training in Robotic-Assisted Surgery that includes a minimum 20 robotic console cases</p> <p>OR</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p><u>NEW to ROBOTICS:</u></p> <p>Board certification, Must have specialty core privileges as appropriate, Must have advanced laparoscopic privileges with documentation of current competence</p> <p>Evidence of original training from da Vinci training program including copy of certificate of completion, course outline, including cadaver and animal lab</p> <p>Proctoring must be completed within 12 months, or applicant must re-apply with <i>new</i> certificate for privilege</p> <p><b>IN ADDITION</b>, must meet the Si and/or Xi criteria by 1) submission of Da Vinci certificate of completion of on-line modules for Si and/or Xi criteria and 2) signed completion of hands-on training with Surgical Intuitive representative for the applicable Da Vinci Si and/or Xi platform and system.</p>	4